Florida State University Law Review

Volume 16 | Issue 3 Article 3

Fall 1988

Medical Malpractice: A New Treatment for an Old Illness

Thomas R. Tedcastle

Marvin A. Dewar

Follow this and additional works at: https://ir.law.fsu.edu/lr

Part of the Legislation Commons, Medical Jurisprudence Commons, and the State and Local Government Law Commons

Recommended Citation

Thomas R. Tedcastle & Marvin A. Dewar, *Medical Malpractice: A New Treatment for an Old Illness*, 16 Fla. St. U. L. Rev. 535 (1988) .
https://ir.law.fsu.edu/lr/vol16/iss3/3

This Article is brought to you for free and open access by Scholarship Repository. It has been accepted for inclusion in Florida State University Law Review by an authorized editor of Scholarship Repository. For more information, please contact efarrell@law.fsu.edu.

MEDICAL MALPRACTICE: A NEW TREATMENT FOR AN OLD ILLNESS

THOMAS R. TEDCASTLE AND MARVIN A. DEWAR

The rising cost of medical malpractice insurance has been one of the most difficult issues faced by the Florida Legislature for many years. In an effort to reach a comprehensive solution to this recurring problem, the 1986 Legislature created the Academic Task Force for Review of the Insurance and Tort Systems, and directed it to conduct a thorough review of Florida's tort system. In 1988, the Legislature implemented several of the recommendations of the Task Force. In this Article, the authors explore the factual findings and the recommendations of the Task Force and analyze the effects that the 1988 legislation will have on the continuing medical malpractice saga.

TABLE OF CONTENTS

I. HISTORY OF MEDICAL MALPRACTICE LEGISLATION IN FLORIDA 537
A. *The 1975 Legislation* 538
B. *The 1976 Legislation* 540
C. *The 1985 Legislation* 541
D. *The 1986 Legislation* 543
E. *The 1987 Legislation* 544
II. TASK FORCE: FINDINGS AND RECOMMENDATIONS 545
A. *Factual Findings* 547
1. *Liability Insurance Industry* 547
2. *Civil Justice System* 549
3. *Medical Profession* 551
B. *Medical Malpractice Recommendations of the Task Force* 554
1. *Prompt Resolution of Claims Plan* 555
2. *No-Fault Plan for Birth-Related Neurological Injuries (BRNI)* 556
3. *Regulatory Reform* 557
4. *Redistribution of Insurance Costs* 559
5. *Negative Recommendations* 559
III. REACHING A LEGISLATIVE CONCENSUS 560

A. The Early Legislative Proposals 562
B. Refining the Task Force Proposals in the Special Session 566
IV. PROMPT RESOLUTION OF CLAIMS 571
V. FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PLAN 582
VI. EMERGENCY ROOM AND TRAUMA CARE LIABILITY REFORM 591
VII. CONCLUSION 595

MEDICAL MALPRACTICE: A NEW TREATMENT FOR AN OLD ILLNESS

THOMAS R. TEDCASTLE* AND MARVIN A. DEWAR**

SOLVING the dilemma between protecting the rights of injured patients and assuring the availability of affordable health care has proved to be an evasive goal for the Legislature of this state and most other jurisdictions. Prior legislative attempts to solve this dilemma have produced mixed results, but have not erased the perception of a continuing liability insurance crisis within the health care professions. Thus, in 1986, after enacting one of the more sweeping tort and insurance law reforms, the Florida Legislature referred the issue to academicians and private citizens for an in-depth, independent evaluation. The results of the study, although modified in the political arena, provided a foundation for a systematic approach to the prevention of medical malpractice incidents and the provision of compensation for injuries resulting from malpractice.

This Article will trace the development of the legislative response and analyze the major tort reform provisions of the 1988 medical malpractice legislation. Although increased regulation of health care professionals also represents a major component of the legislation both in its intent to deter negligent conduct and to remove from the profession those whose abilities leave the public at risk, a thorough discussion of those provisions is left to others to undertake.

I. HISTORY OF MEDICAL MALPRACTICE LEGISLATION IN FLORIDA

The concept of seeking damages for medical maloccurrences dates back to English common law, yet the problems of medical malpractice did not require the full attention of the Florida Legislature until the 1970's. Although health care providers were more likely than the general population to be sued, the disparity did not seem significant enough to warrant the development of legal doctrines separate from those applied to general tort litigation. Medical liability insurance premiums rose sharply in the early 1970's, however, and legislatures throughout the country, including Florida's, focused on reform of the

* Staff Counsel, Florida House of Representatives, House Majority Office. B.S., 1974; J.D., 1977, University of Florida.

** Assistant Professor of Medicine, University of Florida College of Medicine. B.S., 1977, Stetson University; M.D., 1980, University of South Florida; J.D., 1988, University of Florida.

medical malpractice tort system. The early attempts to differentiate medical malpractice reforms from general tort reforms were successful but short-lived. The provisions either were repealed, nullified by the courts, or replaced by provisions affecting the tort system generally. In establishing the Academic Task Force for Review of the Insurance and Tort Systems (Task Force), the Florida Legislature directed that the study be a general review of the tort system.[1] Although supported by various government officials and welcomed by the Legislature, the decision by the Task Force to suggest specific medical malpractice reforms was of its own making.[2] The Task Force determined that the crisis in medical malpractice is of a different nature and magnitude than the problems uncovered in its general tort review[3] and that reliance on the theory of a separate set of rules was desirable. Accordingly, the Task Force reviewed prior legislative enactments which attempted to institute such a system.

A. The 1975 Legislation

In 1975, Florida adopted its first major legislation governing medical malpractice actions.[4] Occasioned by substantial increases in the cost of liability insurance[5] and the withdrawal of many insurers from the market,[6] the primary emphasis of the legislation was in the area of insurance reform, including the creation of a joint underwriting association[7] and a patients' compensation fund as an excess insurer,[8] and expansion of the ability to self-insure.[9] While the insurance reforms remain intact, the Joint Underwriting Association for Medical

---

1. Ch. 86-160, § 63, 1986 Fla. Laws 695, 756.

2. ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS, PRELIMINARY FACT-FINDING REPORT ON MEDICAL MALPRACTICE 1 (Aug. 14, 1987) [hereinafter TASK FORCE FACT-FINDING REPORT].

3. *See id.*

4. Ch. 75-9, § 1, 1975 Fla. Laws 13, 15.

5. Note, *The Florida Medical Malpractice Reform Act of 1975*, 4 FLA. ST. U.L. REV. 50, 51 (1976). Argonaut Insurance Company, the major writer of physician coverage in Florida at that time, raised its rates 96% effective January 1, 1975, and requested another 95% rate hike in April, 1975. *Id.*

6. Prior to the enactment of the Medical Malpractice Reform Act of 1975, more than 20 insurers withdrew from the Florida malpractice liability insurance market. Note, *supra* note 5, at 50 n.3 (citing St. Petersburg Times, Jan. 6, 1975, at B1, col. 2). The largest insurer, Argonaut Insurance Company, threatened to withdraw from the market in 1975 if further rate increases were not granted, but the company was temporarily restrained. Argonaut Ins. Co. v. Florida Medical Assoc., No. 75-140 Civ. (M.D. Fla. May 19, 1975).

7. Ch. 75-9, § 14, 1975 Fla. Laws 13, 24 (amending FLA. STAT. § 627.351 (Supp. 1974)).

8. FLA. STAT. § 627.353 (1975).

9. Ch. 75-9, § 4, 1975 Fla. Laws 13, 16 (amending FLA. STAT. § 627.355 (1973)).

Malpractice Insurance remains a minimal insurer,[10] the Patient's Compensation Fund no longer offers coverage due to a lack of participants,[11] and the expanding self-insurance trust market has produced only limited savings.[12]

The 1975 Act also included substantial tort reforms. It established medical malpractice mediation panels for prior review of malpractice actions,[13] a four-year statute of repose for medical negligence actions (seven-year statute of repose where fraud or concealment is shown),[14] and a statutory definition of "informed consent."[15] To reduce pretrial publicity, the Act also eliminated "ad damnum" clauses so the plaintiff was no longer required to state the amount of damages claimed.[16] While the mediation panels eventually were declared unconstitutional,[17] the concept of providing pre-suit screening has been continuously resurrected and forms an important part of the 1988 legislation.[18] The statutes of repose and the laws governing "informed consent" have undergone only minor changes since their enactment in 1975.[19] The prohibition against pleading the amount of general damages through the elimination of the "ad damnum" clause remains in effect.[20]

---

10. Based on premiums paid in 1985, the Joint Underwriting Association had an estimated 5.5% share of the medical malpractice insurance market. ALLIANCE OF AMERICAN INSURERS, FINANCIAL CONDITION OF MEDICAL MALPRACTICE JUAs ii (June 1987) (prepared for the National Coordinating Committee on Medical Malpractice JUAs).

11. STAFF OF FLA. S. COMM. ON COMMERCE, FLORIDA MEDICAL MALPRACTICE REFORM AND A REVIEW OF COURT-ORDERED ARBITRATION 8 (Jan. 1988) (on file with committee).

12. The rates for the Florida Physician's Protective Trust Fund, effective January 1, 1987, ranged from $9,780 to $170,366 for a policy offering coverage of $1 million per claim per $3 million annual aggregate of claims. Rates for the largest private insurer, which became effective six months later, ranged from $10,325 to $208,503 for the same level of coverage. Attachment to letter from Jerome F. Vogel, Actuary, Fla. Dep't. of Ins., Bureau of Rates, to Bernard Webb, Task Force staff member (Oct. 9, 1987) (on file with Fla. H.R. Comm. on Ins.).

13. Ch. 75-9, §§ 5-6, 1975 Fla. Laws 13, 17 (codified at FLA. STAT. § 768.133 (1975)).

14. *Id.* § 7, 1975 Fla. Laws at 20 (amending FLA. STAT. § 95.11(4) (Supp. 1974)).

15. FLA. STAT. § 768.132 (1975).

16. *Id.* § 768.042.

17. Aldana v. Holub, 381 So. 2d 231 (Fla. 1980). For a detailed review of the use of medical mediation panels in Florida, see Ehrhardt, *One Thousand Seven Hundred Days: A History of Medical Mediation Panels in Florida*, 8 FLA. ST. U.L. REV. 165 (1980).

18. *See* ch. 88-1, §§ 50-53, 1988 Fla. Laws 119, 166 (codified at FLA. STAT. §§ 766.203-.206 (Supp. 1988)).

19. *Compare* FLA. STAT. § 95.11(4) (1987) *with id.* § 95.11(4) (1975) (relating to changes enacted regarding statute of limitations and the statute of repose for medical negligence actions). The medical consent law has been amended only once; the amendment changed a conclusive presumption to a rebuttable presumption. Ch. 85-175, § 21, 1985 Fla. Laws 1180, 1211 (codified at FLA. STAT. § 768.46 (1987)).

20. FLA. STAT. § 768.042 (1987).

B. The 1976 Legislation

Although results from the 1975 Act could not reasonably have been expected within one year, the 1976 Legislature concluded that the 1975 reforms were inadequate.[21] Accordingly, the 1976 Legislature readdressed the medical malpractice issue. Unlike the 1975 Act, the 1976 response was almost entirely in the area of tort reform. It provided for a tighter definition of the standard of care required by a health care provider,[22] a limitation on the doctrine of res ipsa loquitor,[23] and required itemized verdicts.[24] The 1976 Act also provided for periodic payment of future damages[25] and reduction of awards by amounts received from collateral sources,[26] and it codified the role of the court under the doctrines of additur and remittitur.[27] The standard of care adopted in the 1976 Act (that standard "recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances"), and the limitation of the doctrine of res ipsa loquitor, have remained intact since their inception.[28] The other provisions, however, have been repealed or substantially modified, although similar provisions reappeared in later legislative enactments.[29]

The 1976 Legislature also imposed on health care facilities an obligation to engage in internal risk management,[30] and provided for the creation of "medical incident" committees, through which hospital boards determine if a compensable injury had occurred, and if it had,

---

21. Ch. 76-260, 1976 Fla. Laws 660, 662.

> WHEREAS, despite the responsive actions of the 1975 session of the Legislature, professional liability insurance premiums for Florida physicians have continued to rise and, according to the best available projections, will continue to rise at a dramatic rate, and WHEREAS, insurance companies across America are continuing to withdraw from the medical professional liability insurance market so that such insurance, even at exorbitant rates, is becoming virtually unavailable in the voluntary private sector. . . .

Id.

22. FLA. STAT. § 768.45 (Supp. 1976).
23. *Id.* § 768.45(4).
24. *Id.* § 768.48.
25. *Id.* § 768.51.
26. *Id.* § 768.50.
27. *Id.* § 768.49.
28. *See id.* § 768.45 (1987); *id.* § 768.45 (Supp. 1976).
29. *See, e.g., id.* § 768.74 (1987) (relating to additur and remittitur); *id.* § 768.76 (relating to collateral sources); *id.* § 768.77 (relating to itemized verdicts); *id.* § 768.78 (relating to periodic payment of damages).
30. Ch. 76-260, § 2, 1976 Fla. Laws 660, 664 (amending FLA. STAT. § 395.18 (1975)) (codified at FLA. STAT. § 768.41 (Supp. 1976)). Minimal risk management programs were required by the 1975 legislation for the larger hospitals. Ch. 75-9, § 3, 1975 Fla. Laws 13, 16 (codified at FLA. STAT. § 395.18 (1975)).

whether a physician's actions caused or contributed to the injury.[31] The board's decision to offer compensation to an injured patient was binding on both the physician and the physician's insurer and could be challenged only through a binding arbitration program.[32] If the physician or the insurer failed to pay, the committee could pay the award from hospital insurance funds and receive a lien against the physician.[33] Internal risk management remains part of the legislative response to medical malpractice,[34] however the provision for medical incident committees, which came into being on January 1, 1977, lasted only six months before its repeal.[35]

C. *The 1985 Legislation*

The next major legislative attempt to reform the medical malpractice tort system occurred in 1985.[36] That legislation required witnesses to have prior teaching or medical practice to qualify as a medical expert,[37] set limitations on attorney's fees in contingency situations,[38] directed the courts to provide closer scrutiny to damage awards, and strengthened the court's authority to reduce or increase an inappropriate verdict.[39] It was no longer necessary for verdicts to separate awards for medical expenses, lost wages, and other general damages.[40] Rather, verdicts distinguished only between past and future dam-

---

31. FLA. STAT. §§ 768.42-.43 (Supp. 1976).

32. *Id.* § 768.43.

33. *Id.*

34. *See id.* § 395.041 (1987).

35. Ch. 77-64, § 2, 1977 Fla. Laws 98, 100.

36. Ch. 85-175, 1985 Fla. Laws 1180. While the Legislature did adopt a major medical malpractice package in 1977, it represented primarily a reenactment of the 1976 reforms necessitated by a trial court ruling that found the legislation unconstitutional on various grounds. *See* Florida Medical Malpractice Joint Underwriting Assoc. v. Shevin, No. 76-2792 (Fla. 2d Cir. Ct. Feb. 28, 1977), *rev'd and remanded*, 352 So. 2d 174 (Fla. 1977). Additionally, to discourage frivolous claims and encourage early resolution of meritorious claims, the 1980 legislation allowed an award of attorney's fees to prevailing parties in medical malpractice actions. FLA. STAT. § 768.56 (Supp. 1980). This provision, however, was repealed in 1985 because after obtaining an award, defendants were seldom able to collect it. Ch. 85-175, § 43, 1985 Fla. Laws 1180, 1225.

37. Ch. 85-175, § 10, 1985 Fla. Laws 1180, 1195 (amending FLA. STAT. § 768.45(2)(c)(2) (1983)). This requirement does not apply to a "similar health care provider." FLA. STAT. § 768.45(2)(a)-(b) (1985).

38. FLA. STAT. § 768.595 (1985). In accordance with section 768.595(7)(a), this statute was superseded in part by FLA. BAR RULES OF PROF. CONDUCT 4-1.5(F).

39. Ch. 85-175, § 18, 1985 Fla. Laws 1180, 1207 (amending FLA. STAT. § 768.49 (1983)). The 1985 Act authorized the court to employ the doctrines of additur and remittitur where it "appears," as opposed to "clearly appears," that the jury ignored the evidence or where the court found that the verdict is "excessive or inadequate" as opposed to "clearly excessive or inadequate." *Id.*

40. *Id.* § 11, 1985 Fla. Laws at 1196 (amending FLA. STAT. § 768.48 (1983)).

ages.[41] The 1985 Act increased from $200,000 to $500,000 the threshold of future damages that would permit the court to order payment on a periodic basis.[42] Also, it required an evidentiary hearing before punitive damages could be requested.[43]

The 1985 Act also discouraged frivolous litigation by requiring the plaintiff's attorney to reasonably investigate prior to filing a complaint.[44] For example, it encouraged, but did not require, written medical opinions as part of the investigative process.[45] Also, it required plaintiffs to give ninety days' notice to potential defendants before filing a complaint,[46] and required defendants, during the ninety-day period, to make a reasonable investigation.[47] This investigation, however, could be limited to review by an insurance claims examiner without the assistance of medical experts.[48] The pre-suit investigation requirement was designed to encourage settlement prior to judicial involvement in the litigation.[49] With significant revision, these pre-suit investigation provisions laid the groundwork for a major component of the recommendations of the Task Force and the 1988 legislation.[50]

The 1985 Act also established a system of voluntary binding arbitration for cases where defendants admit liability but dispute the damages.[51] A prospective defendant's offer to admit liability and arbitrate the issue of damages could be conditioned on plaintiff's acceptance of a limitation on the plea for general damages.[52] Courts were given authority to refer a medical malpractice case to nonbinding arbitration.

---

41. *Id.*

42. *Id.* § 13, 1985 Fla. Laws at 1197 (amending FLA. STAT. § 768.51 (1983)).

43. FLA. STAT. § 768.495 (1985).

44. *Id.* The statute provides for a 90-day tolling of the statute of limitation upon petitioning the clerk of court for permission to conduct the investigation. *Id.*

45. *Id.* A written medical opinion can be used as evidence to establish that a good faith investigation was conducted. *See id.*

46. *Id.* § 768.57.

47. *Id.*

48. *Id.* § 768.57(3)(a).

49. Hawkes, *The Second Reformation: Florida's Medical Malpractice Law*, 13 FLA. ST. U.L. REV. 744, 762 (1985).

50. The Task Force recommended that a medical expert participate in the investigation and that a written medical expert opinion supporting the claim be obtained before the plaintiff mails a notice of intent to initiate litigation. Similarly, the Task Force recommended that an expert opinion supporting a defense be required prior to the defendant's or insurer's denial of the claim. ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS, MEDICAL MALPRACTICE RECOMMENDATIONS (Nov. 6, 1987) (on file with Fla. H.R. Comm. on Ins. and Fla. H.R. Comm. on Judiciary) [hereinafter TASK FORCE RECOMMENDATIONS].

51. FLA. STAT. § 768.57 (1985).

52. *Id.* No specific dollar limitation is provided. The figure of $250,000 adopted in the 1988 malpractice legislation appeared in earlier drafts of the 1985 proposal, but was replaced with general language. *See* Hawkes, *supra* note 49, at 762 n.78.

However, both parties were free to reject the arbitrator's decision without penalty and demand a trial de novo.[53] Penalties could be imposed if an offer of judgment, or a newly created demand for judgment, was unreasonably rejected.[54] The Act further required pretrial settlement conferences in all medical malpractice cases.[55]

D. The 1986 Legislation

In the following year the Legislature again abandoned the premise that medical malpractice cases were substantially different from other negligence cases when it extended to other negligence laws many of the 1985 reforms, including provisions for pleading punitive damages, providing for structured settlements, and creating a right to demand judgment.[56] However, the 1986 Act, considered in its entirety, was more defense oriented than the legislation adopted in 1985.

The 1986 Act applied the limitation on pleading punitive damages to all negligence cases and added a presumptive limitation on the amount of such damages equal to three times the actual damages.[57] More detailed itemized verdicts were brought back into use, and the court could direct the jury to distinguish not only between past and future damages, but also between those elements of past and future damages which represented economic rather than noneconomic damages.[58] Provisions governing periodic payments were limited to future economic damages rather than all future damages, apparently in recognition of the fact that future noneconomic damages are not subject to reduction to present value.[59] The amount of qualifying damages required for periodic payments was reduced from $500,000 to $250,000.[60]

The Legislature also adopted reforms which had not been included in the medical malpractice legislation of 1985. It approved a $450,000

---

53. FLA. STAT. § 768.575 (1985).

54. *Id.* § 768.585. Costs and attorney's fees are awarded to the defendant if the plaintiff fails to receive an award at trial greater than 75% of the offer of judgment and to the plaintiff if the award is at least 125% of the amount demanded. Although there were no sanctions for requesting a trial de novo, a party willing to abide by an arbitration decision could invoke the offer and demand for judgment sections to have sanctions imposed where the opposing party unreasonably refused to comply with the decision. *Id.*

55. *Id.* § 768.58.

56. *See* ch. 86-160, §§ 51-58, 68, 1986 Fla. Laws 695, 748, 763 (codified at FLA. STAT. §§ 768.72-.79 (1987)).

57. FLA. STAT. §§ 768.73-.74 (Supp. 1986). In 1987 the limits on punitive damages were extended to apply to actions involving misconduct in commercial transactions. *See* ch. 87-42, § 1, 1987 Fla. Laws 177, 178 (amending FLA. STAT. § 768.73 (Supp. 1986)).

58. FLA. STAT. § 768.77 (Supp. 1986).

59. Braddock v. Seaboard Air Line R.R. Co., 80 So. 2d 662, 668 (Fla. 1955).

60. FLA. STAT. § 768.78 (Supp. 1986).

cap on noneconomic damages,[61] but that was declared unconstitutional prior to implementation.[62] The 1986 Act abrogated the doctrine of joint and several liability with respect to noneconomic damages in cases where total damages exceeded $25,000.[63] Additionally, with regard to economic damages, it applied joint and several liability only to a defendant whose percentage of fault equalled or exceeded the plaintiff's.[64]

The 1986 Act also was known for substantial insurance reforms designed to hold down increases in liability insurance rates.[65] Its most important provision, however, at least in relation to medical malpractice actions, was the creation of the Task Force.[66]

E. The 1987 Legislation

The 1987 Legislature enacted some revisions of the tort system even though the 1986 Act was passed on the premise that further reforms would be postponed until the Task Force completed its review of the tort system and reported to the Legislature.[67] The enactments related to offers of settlement and alternative dispute resolution. Like the 1986 provisions, they were directed to the tort system as a whole, and served as a further indication of legislative interest in encouraging the early amicable settlement of claims.[68]

The adoption of a demand for judgment provision was intended to even the playing field between plaintiffs and defendants by permitting

---

61. *Id.* § 768.80.

62. Smith v. Department of Ins., 507 So. 2d 1080 (Fla. 1987).

63. FLA. STAT. § 768.81 (Supp. 1986).

64. *Id.*

65. Among the findings of the Legislature in adopting The Reform and Insurance Act of 1986 was a determination that "the tort law and the liability insurance system are interdependent and interrelated" and therefore a need existed for reform of both the insurance regulatory statutes and the tort law of Florida. *See* ch. 86-160, 1986 Fla. Laws 695, 699.

66. The Task Force was established to conduct a scholarly review of the insurance and tort laws of Florida and other jurisdictions. *Id.* § 13, 1986 Fla. Laws at 756. On November 6, 1987, the Task Force made recommendations to the Legislature for reform in the area of medical malpractice. These recommendations formed the basis for the 1988 legislative response to the medical malpractice issue.

67. *See* FLA. STAT. §§ 45.061-.062 (1987) (governing offers of settlement); *id.* ch. 44 (allowing court-ordered mediation, court-ordered nonbinding arbitration, and voluntary binding arbitration.)

68. *Id.* Sections 44.303 and 45.061 permit assessment of costs and attorney's fees against a party who unreasonably proceeds to trial. In a de novo hearing in arbitration, the requesting party must obtain a more favorable result than that obtained in arbitration. Where there is an offer of settlement, that offer shall be presumed to have been unreasonably rejected by a defendant if the judgment entered is at least 25% greater than the offer rejected, and an offer shall be presumed to have been unreasonably rejected by plaintiff if the judgment entered is at least 25% less than the offer rejected. *Id.* § 45.061.

the plaintiff an opportunity to receive the benefit of sanctions imposed for the unreasonable rejection of an offer. However, the defendant remained in a position of having to admit to the entry of a judgment determining liability in either case. To remove this stigma of admitted liability, the 1987 Legislature extended the sanctions to cases where an offer of settlement made by either party was unreasonably rejected.[69] In this manner, both parties were further encouraged to reach out-of-court settlements, physicians were not required to submit to the entry of a finding of liability, and no public record of the amount of the settlement would be created.

In establishing a voluntary binding arbitration program under which parties could agree to arbitrate existing disputes, the Legislature sought to provide an alternative forum for the parties to settle their dispute. However, before a physician or a physician's insurer could offer to arbitrate, the arbitration provisions adopted in 1987 first required an admission of liability.[70] The 1987 Act also permitted both parties to agree in writing to submit their disputes to binding arbitration.[71] Courts also were given the authority to refer disputes either to nonbinding arbitration or to mediation.[72] If the court ordered nonbinding arbitration, sanctions would be imposed on a party seeking a trial de novo if the judgment obtained in the trial was not more favorable to the requesting party than the arbitration order.[73] Court referral to mediation or nonbinding arbitration, however, was limited to judicial circuits in which an appropriate program was available.[74]

II. Task Force: Findings and Recommendations

The Task Force created by the 1986 legislation[75] consisted of five members: three designated by the legislation and two appointed by the designated members.[76] The three designated members were university Presidents Marshall M. Criser of the University of Florida, Bernard F. Sliger of the Florida State University, and Edward T. Foote, II, of the University of Miami. The two appointed members were business-

69. *Id.* § 45.061.

70. *Id.* § 768.57(3)(b)(3).

71. *Id.* § 44.304. Presumably, before providing elective care and possibly emergency treatment, health care practitioners could require patients to agree to submit any claim arising from the treatment to binding arbitration.

72. *Id.* §§ 44.302-.303.

73. *Id.* § 44.303(5).

74. *Id.* §§ 44.302(1), .303(1).

75. *See supra* note 66.

76. *Id.*

men Preston H. Haskell of Jacksonville and P. Scott Linder of Lakeland.[77]

The Task Force was charged with the responsibility of studying the issues of affordability and availability of liability insurance, as well as the efficacy of previous legislative attempts to reform the tort and liability insurance systems.[78] The Task Force members assembled a research staff of experts in law, insurance, and medicine[79] which conducted an extensive empirical analysis of Florida's liability insurance and tort systems.[80] Although initially scheduled to provide its findings and recommendations to the Legislature by March 1, 1988, Governor Martinez requested the Task Force to provide findings and recommendations in the area of medical malpractice on an accelerated schedule in preparation for a special legislative session on medical malpractice.[81]

In response to the Governor's request, the Task Force produced two major reports on medical malpractice: the *Preliminary Fact-Finding Report on Medical Malpractice*[82] and *Medical Malpractice Recommendations*.[83] Since the Legislature relied heavily on the Task Force's

---

77. ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS, ADMINISTRATIVE REPORT 2 (March 30, 1988) [hereinafter ADMINISTRATIVE REPORT].

78. *See id.*

79. Members of the Task Force research staff participating in the Preliminary Fact-Finding Report on Medical Malpractice and the formulation of medical malpractice recommendations included: Executive Director Carl S. Hawkins, Professor and former Dean, Brigham Young University Law School; Associate Director Donald G. Gifford, Professor of Law, University of Florida; Dr. David J. Nye, Associate Professor of Finance and Insurance, University of Florida; Joseph W. Little, Professor of Law, University of Florida; Dr. Roger G. Blair, Professor of Economics, University of Florida; Bernard L. Webb, Professor of Actuarial Science, Risk Management and Insurance, Georgia State University; and Marvin A. Dewar, M.D., practicing physician and law student. ADMINISTRATIVE REPORT, *supra* note 77, at 2-3.

80. This Article focuses on the findings and recommendations of the Task Force that relate to medical malpractice; however, the scope of the Task Force's investigations and recommendations was not limited to medical malpractice. The findings and recommendations in areas of liability insurance and tort law, other than medical malpractice, can be found in two publications: (1) ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS, FINAL FACT-FINDING REPORT ON INSURANCE AND TORT SYSTEMS (March 1, 1988), and (2) ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS, FINAL RECOMMENDATIONS (March 1, 1988).

81. Several events led to the perceived need for a special legislative session on medical malpractice. Late in 1986, the state's three largest medical malpractice insurers disclosed plans to increase premium rates by as much as 35%. In response, some physicians, particularly in South Florida, began curtailing high-risk services. The most publicized episodes involved emergency rooms closing or curtailing services. *See* Nordheimer, *Doctors Withhold Services in Protest of Insurance*, N.Y. Times, Dec. 10, 1986, at A25, col. 1; *Florida Hospitals Curtail Services as Doctors Protest Insurance Costs*, N.Y. Times, Jan. 2, 1987, at D14, col. 1; *Hospitals in Florida Cut Certain Services as Protest Continues*, N.Y. Times, Jan. 3, 1987, at 8, col. 3.

82. TASK FORCE FACT-FINDING REPORT, *supra* note 2.

83. TASK FORCE RECOMMENDATIONS, *supra* note 50.

findings in formulating the 1988 legislative response to medical malpractice, the factual findings and recommendations of the Task Force will be reviewed here.

A. *Factual Findings*

The Task Force conducted an extensive analysis of data relating to the medical malpractice and liability insurance systems. This investigative effort included state-wide public hearings and a comprehensive review of the relevant literature.[84] Additionally, the Task Force research team conducted several original research projects designed to collect Florida-specific data on medical malpractice and liability insurance.[85] These investigations led to a series of specific factual findings on the medical malpractice and liability insurance system in Florida.[86] The findings can be grouped as follows: (1) findings regarding the liability insurance industry; (2) findings regarding the civil justice system; and (3) findings regarding the medical profession.

1. *Liability Insurance Industry*

The Task Force's factual findings regarding the liability insurance industry are the result of an exhaustive analysis of paid medical malpractice claims from 1977 through 1986 and an analysis of insurance company finances.[87] The Task Force found that between 1983 and 1986, the cost of medical malpractice insurance rose substantially, both in absolute terms and when compared to physicians' gross revenues.[88] The increase was most dramatic for physicians in South Florida, with obstetricians & gynecologists in Dade and Broward counties experiencing an average annual premium increase of 45.7%.[89] Although medical malpractice insurance was costly, no evidence existed that physicians were unable to obtain insurance coverage during the study period.[90]

---

84. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 2-3.

85. The original research projects included: (1) a survey of all closed malpractice claims paid from 1975 to 1986 (a closed claim is a claim which has either been settled, dropped or litigated to a conclusion); (2) a survey of companies offering liability insurance in Florida; (3) an investigation of insurance company finances; (4) a survey of Florida physicians; (5) a survey of Florida attorneys; and (6) an analysis of civil litigation rates in Florida. *Id.* at 3.

86. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 6-17.

87. *Id.* at 23-24.

88. *Id.* at 26-36.

89. *Id.* at 30.

90. *Id.* at 37-43. The Task Force recognized the possibility that liability insurance, though technically available, could become so costly as to be "functionally unavailable." *Id.* at 37.

The Task Force determined that the substantial rise in the cost of medical liability insurance resulted from a sustained increase in the total amount of malpractice claims paid.[91] This increase in loss payments was produced by an increase in both the number of claims paid and the amount paid per claim.[92] From 1975 to 1986 the average paid medical malpractice claim grew at a compound average rate of nearly 15%.[93] During the same period, the frequency of paid claims increased at an annual compound rate of almost 5%.[94] As a result of this increase in claims' severity and frequency, the Task Force determined that total medical malpractice claims paid from 1975 to 1986 grew at a compound rate in excess of 20% per year.[95]

A frequently heard assertion during discussions on the medical malpractice insurance crisis was that, despite claims to the contrary, liability insurers enjoy inordinate profits from medical malpractice liability policies.[96] However, the Task Force's study of the medical malpractice liability insurance industry in Florida does not support that assertion. Based upon a 1987 study conducted by the Insurance Services Office, the Task Force concluded that the profitability of medical malpractice insurers was comparable to the profitability of the average U.S. industrial and financial institution for the period of 1977 to 1985.[97] Although liability insurance company profitability varied substantially on a yearly basis due to changes in the underwriting cycle and premium investment returns, the Task Force concluded that excess malpractice liability insurer profitability was not a major cause of rising premiums during the study period.[98]

However, the Task Force found that the insurance industry practice of setting premium rates by dividing Florida physicians into a limited number of "risk classifications," determined by specialty and geographic location, contributed to affordability problems experienced by some high-risk specialties.[99] Apparently, the limited number of medi-

---

91. *Id.* at 44.

92. *Id.* at 49. The Task Force studied both the frequency and size of loss payments, but did not attempt to establish whether payments under existing liability rules, or whether the existing liability rules themselves, were appropriate. *Id.*

93. *Id.* at 128.

94. *Id.* at 126. The frequency of claims reported in South Florida was twice that reported by the rest of the state. Additionally, certain medical specialties, such as orthopedics and obstetrics & gynecology, accounted for increasing proportions of paid claims. *Id.* at 118-24.

95. *Id.* at 44-46. The compound annual growth rate since 1979 was more than 30%. *Id.*

96. *See, e.g.*, Horwitz, *Nader Charges Insurers with Price-Gouging*, Wash. Post, Jan. 7, 1986, at D1, col. 6 (insurers are "price-gouging the public").

97. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 53-57.

98. *Id.* at 8-9.

99. *Id.* at 10-11, 97-108.

cal practitioners in the high-risk classifications such as obstetrics & gynecology and neurosurgery fails to provide enough cost spreading to mitigate the heavy loss experiences of these specialties. Consequently, physicians in high-risk specialties face malpractice insurance premiums many times greater than physicians in low-risk specialties.[100]

Additionally, the Task Force examined the possibility that the relatively small number of firms writing medical malpractice insurance in Florida created a monopoly situation resulting in insufficient competition and high premiums. Despite finding that eighty percent of the medical malpractice liability insurance in Florida was underwritten by four firms,[101] the Task Force determined that market monopoly conditions are not a substantial cause of the increased cost of medical malpractice insurance.[102]

2. *Civil Justice System*

The Task Force also considered the possible contribution of changes in the tort system to rising malpractice insurance premiums. The Task Force's evaluation included an analysis of closed medical malpractice claims,[103] an evaluation of civil litigation rates,[104] and a

---

100. *Id.* at 27. Family physicians in Dade and Broward counties paid an average of $19,415 in 1987 for liability insurance. Family physicians in the rest of the state paid an average of $10,277. In contrast, neurosurgeons in Dade and Broward counties paid an average annual premium of $192,420, while Florida's neurosurgeons practicing outside the Dade/Broward area paid an average of $102,339 annually for malpractice coverage. *Id.*

101. *Id.* at 64-73. Although this represents a high degree of market concentration, Florida ranks thirty-fifth when compared to other states as to the degree of concentration of the malpractice insurance market. *Id.* at 68-72.

102. *Id.* at 8-9, 73-86. The Task Force staff examined the following factors to evaluate the difficulty of entering the Florida medical malpractice insurance market: statutory and regulatory requirements; business considerations; and legal environment considerations. The Task Force concluded that these factors did not make it unduly difficult to enter Florida's insurance market. *Id.* at 80-83.

103. The analysis of closed medical malpractice claims involved consideration of data provided by the Florida Department of Insurance. In 1974, Florida enacted legislation which required insurance carriers to report information on medical malpractice claims to the Florida Department of Insurance. FLA. STAT. § 627.912 (1987). As a result of this requirement, the Department of Insurance received more than 21,000 claims reports between 1975 and 1986. For an analysis of the Florida Department of Insurance medical malpractice closed claims data set, see Nye, Gifford, Webb & Dewar, *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L.J. 1495, 1537-60 (1988) [hereinafter *An Analysis of Claims Data*].

104. Florida civil litigation rates were analyzed using data obtained from the State Courts Administrator's Office. A comparison of Florida's civil litigation rates with national rates can be found in Gifford & Nye, *Litigation Trends in Florida: Saga of a Growth State*, 39 U. FLA. L. REV. 829 (1987).

survey of Florida lawyers.[105] The Task Force found that medical malpractice tort system transaction costs (litigation costs and attorney's fees) increased substantially from 1975 to 1986.[106] Changes in the rules of medical malpractice tort law, however, were not entirely responsible for the large increases in the cost of medical malpractice liability insurance during this period.[107] Unfortunately, data sufficient to determine changes in the number of medical malpractice tort lawsuits filed in Florida over the study period were not available.[108]

Opponents of the medical malpractice tort system frequently complain that it is an inefficient mechanism for compensating the victims of medical maloccurrences.[109] They argue that the operation of the tort system itself, in the form of litigation costs and attorney's fees, consumes an inordinate amount of resources. Indeed, the Task Force found that only 43% of the total insurance company expenditures for medical malpractice in 1985 actually was paid to plaintiffs. Plaintiffs' legal costs constituted more than 21% of the total expenditures, while defense costs consumed 18%. The cost of defending a medical malpractice claim grew at an annual rate of 17% between 1975 and 1986.[110]

Though increases in the cost of defending medical malpractice claims could be responsible for some of the increase in liability insurance costs, the Task Force was unable to document a correlation between particular changes in substantive medical malpractice tort law and increased liability insurance costs.[111] Changes in Florida's malpractice liability rules since 1970 have not been either pro-plaintiff or pro-defendant. However, the expansion of the standard of care in medical malpractice cases from a local to a national standard, and the use of tort doctrines such as res ipsa loquitor, have altered the medical

---

105. The Task Force staff conducted a survey of 1,500 Florida attorneys who practice tort law. The survey included an equal number of plaintiff and defense attorneys and was designed to elicit information about the attorney's individual practice as well as perceptions about the tort system in general. *See* TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 216 n.224.

106. *See infra* note 110 and accompanying text.

107. *See infra* notes 111-13 and accompanying text.

108. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 150-51. The medical malpractice closed claims database includes information on all medical malpractice insurance claims since 1975 which resulted in a lawsuit, as well as claims which were resolved without a lawsuit being filed. *See An Analysis of Claims Data*, *supra* note 103. On the other hand, the State Courts Administrator's Office did not begin collecting data on the actual number of medical malpractice lawsuits filed until 1986. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 150.

109. *See* P. DANZON, MEDICAL MALPRACTICE 187-207 (1985).

110. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 198.

111. *Id.* at 188-89.

malpractice tort law rules in a pro-plaintiff manner.[112] On the other hand, the Legislature made several forays into the field of medical malpractice tort law in an apparent attempt to limit the tort liability of health care providers. Examples of defense-oriented changes in tort rules include statutory limitations on the measure of damages in medical malpractice actions and the creation of conditions precedent to the filing of medical malpractice lawsuits.[113]

3. *Medical Profession*

The Task Force evaluated the relationship of the medical profession to the malpractice tort system. This evaluation included an analysis of malpractice claims records of individual health care providers and different medical specialties. Additionally, the Task Force conducted a survey of Florida physicians to ascertain their impressions of the medical malpractice tort system and the effects of tort liability on the practice of medicine. The Task Force did not attempt to evaluate individual medical malpractice claims and, therefore, did not make judgments as to the merit of particular claims.

Analysis of closed medical malpractice claims revealed a significant disparity in the distribution of claims among individual physicians and

---

112. *Id.* at 159-70. The standard of care for a Florida health care provider practicing as a "specialist" is determined by reference to other health care providers practicing in the same specialty. FLA. STAT. § 768.45(2)(b) (1987). Health care providers not certified as specialists are held to a standard of care that is determined by reference to "similar health care providers" licensed in Florida. *Id.* § 768.45(2)(a). Res ipsa loquitor is a tort rule which allows juries to infer a defendant's negligence under certain circumstances. *See* W. PROSSER & W. KEETON, TORTS § 39 (5th ed. 1984). Florida courts have permitted limited use of res ipsa loquitor in medical malpractice actions. *See e.g.* Marrero v. Goldsmith, 486 So. 2d 530 (Fla. 1986); Chenoweth v. Kemp, 396 So. 2d 1122 (Fla. 1981); Benigno v. Cypress Community Hosp., 386 So. 2d 1303 (Fla. 4th DCA 1980).

113. Several statutes limit the recovery of damages in medical malpractice cases. For example, punitive damages are limited to three times the sum of compensatory damages and 60% of any punitive damage award is paid to the state rather than to the plaintiff. *See* FLA. STAT. § 768.73 (1987). An attempt to limit by statute noneconomic damages in negligence actions, including medical malpractice actions, to $450,000 was declared unconstitutional by the Supreme Court of Florida. Smith v. Department of Ins., 507 So. 2d 1080 (Fla. 1987). For a discussion supporting the constitutionality of the proposed cap on noneconomic damages see Note, *The Constitutionality of Florida's Cap on Noneconomic Damages in the Tort Reform and Insurance Act of 1986*, 39 U. FLA. L. REV. 157 (1987).

An example of a statutory condition precedent to filing a medical malpractice lawsuit is the requirement that lawyers make a "reasonable investigation" before filing a claim sufficient to create a "good faith belief" that adequate grounds exist for the claim. FLA. STAT. § 768.495(1) (1987). Additionally, plaintiffs are required to provide defendants with 90-day notice before filing a medical malpractice action in order to encourage pre-suit investigation and settlement. *Id.* § 768.57(3)(a). In 1975, an attempt to require that medical malpractice cases proceed through mediation proceedings before trial was declared unconstitutional as applied. Aldana v. Holub, 381 So. 2d 231 (Fla. 1980). For an extensive discussion of the Florida experience with mandatory medical mediation panels, see Ehrhardt, *supra* note 17.

medical specialties. High-risk medical specialties, such as orthopedics and obstetrics & gynecology, experienced paid claims at a rate two to three times the statewide average for all medical specialties combined.[114] Medical specialties that accounted for an increasing proportion of paid claims from 1975 to 1986 include orthopedics, obstetrics & gynecology, and emergency medicine.[115]

With respect to the distribution of medical malpractice claims among individual physicians, the Task Force encountered a similar disparity. Of the 5,503 medical malpractice claims from 1975 to 1986 that resulted in an indemnity payment, physicians with a single paid claim accounted for 79%.[116] Of the remaining claims, physicians with two paid claims accounted for 14%.[117] Even more striking is the comparison between the number of paid claims per physician and the total amount of indemnity payments made during the study period. The 867 physicians (approximately 4% of the physicians in Florida) with two or more paid claims accounted for 42% of the more than $500 million paid out in medical malpractice indemnity payments between 1975 and 1986.[118] The Task Force was careful not to imply that physicians with multiple claims necessarily were "bad doctors;"[119] however,

---

114. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 115-18. In 1985, the rate of paid medical malpractice claims in Florida was 3.54 per 100 physicians. The rates for orthopedic and obstetric & gynecologic specialists were 9.99 and 8.05 per 100 physicians, respectively. In contrast, a relatively low-risk specialty, such as internal medicine, experienced a claims rate of 1.21 per 100 physicians. *Id.*

115. *Id.* at 123. The increases were most dramatic for orthopedics and emergency medicine. Emergency medicine accounted for only 0.8% of all closed claims in 1975; by 1982 emergency medicine accounted for 8.9% of all closed claims. Some specialties, most notably general practice, general surgery, and anesthesiology, experienced a decline in their relative proportion of total closed medical malpractice claims. *Id.* This pattern of redistribution among medical specialties is at least partially attributable to shifts in physician demographics during the study period. For example, from 1970 to 1982, the percentage of physicians classified as obstetricians & gynecologists increased 48% and the percentage classified as orthopedic surgeons increased 68%. During the same time period, the percentage of physicians classified as general or family physicians decreased by 0.1%. AMERICAN MED. ASS'N COUNCIL OF LONG RANGE PLANNING & DEV., THE ENVIRONMENT OF MEDICINE 44 (1985). Altered physician demographics do not completely explain the changes in specialty distribution of malpractice closed claims. This is demonstrated by the fact that the specialty of anesthesiology experienced a decreased claims' rate despite a 67% increase in representation in relative physician supply. *Id.* For the suggestion that the decreased claims' rate among anesthesiologists represents an increase in the quality of care delivered by the specialty, see Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.)*, 73 CORNELL L. REV. 170, 186 n.46 (1988).

116. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 145.

117. *Id.* The dubious distinction of having the greatest number of paid claims went to a physician with 34.

118. *Id.* at 146.

119. *Id.* at 142-43. Incompetence is a potential cause of physicians with multiple claims. Other potential causes of multiple claims include practice in a high-risk medical specialty or a high-risk geographical location. The specialties with the largest numbers of physicians with multiple claims were obstetrics & gynecology, orthopedics, general surgery, and general practice. *Id.*

the clustering of a large percentage of the paid claims among a relatively small group of physicians does suggest that regulatory reform could have an impact on the medical malpractice problem.[120]

The Task Force recognized that any evaluation of medical malpractice needed to include an analysis of the effect of professional liability on the medical profession. Accordingly, the Task Force surveyed Florida physicians to evaluate the following aspects of the medical malpractice system: (1) financial effects on physicians; (2) effects on health care costs; and (3) alterations in patterns of health care delivery.

The survey indicates that both the absolute cost of professional liability insurance and liability insurance premium costs as a percentage of physicians' gross income increased steadily from 1971 to 1987.[121] For the insurance policy year 1971 to 1972, physicians paid a mean liability premium of $4,645, representing 4.2% of gross practice revenues. By policy year 1986 to 1987, the mean liability premium increased to $23,747, and absorbed an estimated 11.6% of physicians' gross revenues.[122] The Task Force concluded that liability insurance was an increasing financial burden to physicians generally, and "[f]or some . . . so costly as to be 'functionally unavailable.'"[123]

In response to increased liability premiums, physicians absorbed some of the added costs and shifted the remainder to consumers by increasing fees for health services. Of the physicians responding to the

---

120. The Florida Department of Professional Regulation (DPR) is responsible for regulating the medical profession. Section 627.912(3), Florida Statutes (1987), requires that the Department of Insurance notify DPR of any physician who experiences more that three paid medical malpractice claims, each exceeding $10,000, in a period of five years. The Task Force determined that DPR had investigated 36 physicians on this basis since November 1985. Of these, only five investigations resulted in some type of disciplinary action against the physician involved. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 231. These statistics suggest that vigorous regulation of the medical profession might reduce the number and size of malpractice indemnity payments. For an assertion that regulatory deficiencies are the key to the medical malpractice crises, see WOLFE, BERGMAN & SILVER, MEDICAL MALPRACTICE: THE NEED FOR DISCIPLINARY REFORM, NOT TORT REFORM, PUBLIC CITIZEN HEALTH RESEARCH GROUP REPORT (1985); Relman, *Professional Regulation and the State Medical Boards*, 312 NEW ENG. J. MED. 784, 785 (1985).

121. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 236-39. The Task Force's findings in this regard are consistent with the findings of other investigators. *Compare* Kirchner, *Is Your Practice Begging for Money?*, MED. ECON., Nov. 12, 1984, at 214, 230 (U.S. physicians in 1983 spent between 1.3% and 5.8% of gross practice income on professional liability insurance) *with* UNITED STATES GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION 2 (1987) (insurance costs as a percentage of gross business expenses for physicians grew from 8% in 1983 to 10% in 1985).

122. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 237. The increases in the absolute and relative cost of liability insurance demonstrate a striking variation across medical specialties. For example, although the average physician expended 11.6% of gross practice revenues for liability insurance, the figure for obstetricians & gynecologists was 23.1%. *Id.*

123. *Id.* at 239-40.

Task Force survey, sixty-six percent reported increasing health care fees in response to rising liability premiums. Physicians estimated that the cost of liability insurance was responsible for thirty-four percent of their total fee increases.[124]

The Task Force also considered the possibility that physicians' health care delivery patterns have been altered by the medical malpractice system. Eighty percent of physicians reported ordering more diagnostic testing as a result of concern about medical malpractice. Increased diagnostic testing induced by concern over medical malpractice may indicate that negligent behavior is being deterred; however, increased testing motivated by fear of professional liability—not justified by sound medical principles—represents an undesirable effect of the medical malpractice system.[125] In addition to increased diagnostic testing, physicians reported increased consultations, maintaining more detailed records and providing more comprehensive informed consent as a result of concern about medical malpractice.[126] Over half of the physicians reported being more selective in the patients they treat and less willing to care for patients with "difficult" medical problems. Eighteen percent of physicians indicated an unwillingness to see emergency room or trauma patients because of liability concerns.[127]

B. Medical Malpractice Recommendations of the Task Force

On the basis of the factual findings discussed above, the Task Force forwarded several specific recommendations to the Florida Legislature.[128] The Task Force recommended reforming the medical malpractice tort system as well as strengthening the medical regulatory system. Additionally, the Task Force proposed a mechanism by which physi-

---

124. *Id.* at 240. A recent study attempted to identify the relationship between the cost of professional liability insurance and the cost of various health services. The study concluded that 20% to 25% of the cost of a routine office visit to a physician and an electrocardiogram analysis was attributable to the cost of professional liability insurance. The study also concluded that 36% of the cost of a hysterectomy and 43% of the cost of routine obstetric care was attributable to liability insurance costs. *See* Reynolds, Rizzo & Gonzalez, *The Cost of Medical Professional Liability*, 257 J. A.M.A. 2776 (1987) [hereinafter *Medical Professional Liability*].

125. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 242-44. *See generally* Hermis, *Defensive Medicine: It Costs, But Does It Work?*, 257 J. A.M.A. 2801 (1987) (asserting that each $1 increase in liability premiums generates an estimated $3.50 in defensive medicine costs); *Medical Professional Liability*, *supra* note 124, at 2781 (suggesting that the annual cost of defensive medicine nationally approaches $13.7 billion); Zuckerman, Koller & Bovberg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS. 85, 99 (1986) (increased diagnostic testing justified in terms of cost/benefit analysis is desirable).

126. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 244.

127. *Id.* at 248.

128. TASK FORCE RECOMMENDATIONS, *supra* note 50.

cians who experience financial difficulty due to liability insurance premiums could obtain temporary relief. Since these recommendations served as the starting point for the Legislature's consideration of the medical malpractice problem, they are summarized below.

1. Prompt Resolution of Claims Plan

The principal civil justice reform advanced by the Task Force is entitled the Prompt Resolution of Meritorious Medical Negligence Claims Plan.[129] The Plan combines two basic proposals: (1) as a preliminary matter, both plaintiffs and defendants should be required to conduct pre-suit investigations and to document that reasonable grounds exist for initiating or denying a malpractice claim; and (2) incentives should be provided for plaintiffs and defendants to encourage the parties to settle disputes through voluntary binding arbitration.

The prompt investigation portion of the Task Force's proposal would require a qualified expert's written corroborating opinion to accompany the filing of both claims and defenses. Penalties would be imposed on both plaintiff and defendant who fail to comply with the pre-suit reasonable investigation requirements.[130] The driving goal behind the prompt investigation portion of the Task Force's plan is to promote an early distinction between meritorious and nonmeritorious claims, thus permitting claims to be settled earlier and transaction costs to be reduced.[131]

Once the early investigation requirements were satisfied, the plan would allow either the plaintiff or the defendant to offer to resolve the claim by submitting to voluntary binding arbitration.[132] If the parties agreed to arbitrate, the arbitration panel would determine only the amount of damages the plaintiff is entitled to recover. Under this proposal, the defendant's offer to arbitrate would not be considered an admission of liability; however, it would constitute a binding commit-

---

129. *Id.* at 15-27.

130. *Id.* at 19. The Task Force proposed that: (1) plaintiffs filing claims without obtaining a corroborating expert opinion should have their claims dismissed and attorney's fees and court costs assessed against them; and (2) defendants answering a complaint by denying it, without first obtaining a corroborating expert opinion, should have their answer stricken and be assessed court costs and attorney's fees. Additionally, the Task Force proposed that attorneys filing claims without complying with pre-suit screening requirements be subject to disciplinary proceedings by The Florida Bar. Likewise, physicians providing written opinions without reasonable investigation should be subject to discipline by the Department of Professional Regulation. *Id.* at 19-20.

131. *Id.* at 15-16.

132. *Id.* at 21-27.

ment to pay the plaintiff the damages awarded by the arbitration panel. On the other hand, if the plaintiff submits to arbitration, the damage award determined by the arbitration board would be the exclusive avenue of recovery.[133]

Certain incentives are built into the Task Force's plan to encourage the parties to submit meritorious claims to binding arbitration. The plaintiff's incentive to submit a claim to binding arbitration is the right to a damage award without having to prove fault. Additionally, submitting claims to arbitration avoids much of the delay and the high transaction costs involved in pursuing a claim through the courts.[134] The incentive for defendants to submit to binding arbitration is provided by conditional limitations placed on noneconomic damage awards. For cases submitted to arbitration, the Task Force proposed that noneconomic damages be limited in each case to a maximum of $250,000, calculated as a percentage of the plaintiff's estimated loss of capacity to enjoy the amenities of life.[135]

Where a defendant offers to submit to binding arbitration but the plaintiff declines the offer, the case would proceed to trial with a $350,000 cap on noneconomic damages.[136] If a defendant refuses a plaintiff's arbitration offer, the case would proceed to trial without any damage caps. A plaintiff prevailing at trial in this situation would be entitled to prejudgment interest and an award of reasonable attorney's fees.[137]

2. *No-Fault Plan for Birth-Related Neurological Injuries (BRNI)*

The second major reform that the Task Force advanced is a proposal to compensate on a no-fault basis infants who receive severe neurological injuries during the birth process.[138] The decision to treat

---

133. *Id.* at 21-23.

134. *Id.* at 11.

135. *Id.* at 22.

136. *Id.* at 17. The Task Force considered the potential constitutional dimensions of the caps on noneconomic damages. The caps in the Prompt Resolution of Meritorious Medical Negligence Claims Plan were distinguished from the $450,000 absolute cap on noneconomic damages declared unconstitutional in Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987). Under the Prompt Resolution Plan, the plaintiff's quid pro quo for the imposition of the cap is the opportunity to receive damages as determined at arbitration without having to prove the defendant's negligence. The damage cap is imposed only when the plaintiff is first offered this opportunity but refuses it.

137. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 17.

138. *Id.* at 30-34. The Task Force recommendation is based on 1987 Virginia legislation. *See* VA. CODE ANN. §§ 38.2-5000 to -.5021 (1988). For further discussion of the Virginia legislation and the similar legislation adopted in Florida, see *infra* notes 353-423 and accompanying text.

birth-related neurological injuries differently from other medical maloccurrences flowed from evidence that the costs of the medical malpractice system are particularly high in obstetrics.[139] In addition, the plaintiffs in obstetrical cases often are infants with substantial injuries. This plan would provide guaranteed compensation for a class of severely injured infants in need of assistance.

The BRNI plan is a "designated compensable event" no-fault plan that provides automatic scheduled compensation to all claimants who meet entry requirements.[140] The Task Force proposed that the compensable event for the BRNI plan would be:

> injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-natal period . . . render[ing] the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living.[141]

The Task Force proposed that an administrative agency (the Division of Workers' Compensation) determine the eligibility of claimants and administer the plan.[142]

For eligible infants, the Task Force recommended that this plan be the sole remedy for the injuries sustained. Compensation would be limited to net economic losses.[143] Physician participation in the BRNI plan would be voluntary for hospitals and obstetricians.[144] Obstetricians and hospitals who elect to participate in the plan would be required to provide to patients notice of their involvement.[145] The damages awarded under this proposal would be funded by assessments against physicians and participating hospitals.[146]

3. *Regulatory Reform*

Along with recommendations for reforms in the medical malpractice tort and insurance systems, the Task Force made specific propos-

---

139. *See supra* notes 94, 99, 114-15, 122, and accompanying text.

140. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 31-32.

141. *Id.* This definition was taken verbatim from the Virginia statute. VA. CODE ANN. § 38.2-5001 (1988).

142. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 33.

143. *Id.*

144. *Id.*

145. *Id.* at 34. This is the same approach taken by the Virginia plan. The no-fault remedy is available only to infants whose medical care is provided by a participating physician. Infants who receive similar injuries and who are under the care of non-participating physicians must rely on existing tort law for a remedy. VA. CODE ANN. § 38.2-5008(2)-(5) (1988). The Task Force's suggestion that participating physicians notify their patients is a departure from the Virginia legislation. *See id.*

146. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 33.

als aimed at strengthening the regulation of health care providers. Prompting these recommendations was evidence that paid malpractice claims have been clustered among a relatively small number of health care providers.[147] The goal of regulatory reform is to reduce the total costs of the medical malpractice system by reducing the number of medical maloccurrences.[148]

The Task Force recommended that the Florida Department of Professional Regulation (DPR) create a Division of Medical Quality Assurance responsible for licensure of health care providers as well as quality assurance and professional discipline.[149] The Division of Medical Quality Assurance would coordinate health care provider quality assurance and discipline at both the state and local levels. Grievance committees composed of local physicians would be established on county or district levels. Complaints against health care providers would be screened by these local bodies, and findings and recommendations would be forwarded to the Division of Medical Quality Assurance for further action. Participants in this peer review process would be provided with civil and antitrust immunity for their actions.[150]

To ensure that the Division of Medical Quality Assurance would be adequately funded, the Task Force suggested that physician licensing fees be substantially increased.[151] The Task Force proposed that DPR evaluate the following additional regulatory reforms to determine their desirability: (1) increasing the residency training requirement for initial medical licensure; (2) raising the requirements for continuing medical education; and (3) consideration of periodic relicensure examinations.[152] Finally, the Task Force recommended that the "clear and convincing evidence" standard of proof for DPR disciplining of health care providers be changed to a "preponderance of the evidence" standard.[153]

---

147. *See supra* notes 117-20 and accompanying text.

148. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 37.

149. *Id.* at 40-44. Before the Department of Professional Regulation existed, the regulation of health care providers was allocated to several different divisions. The Division of Professions was responsible for the licensing and discipline of health care providers as well as over 30 other professions. The Division of Regulation was responsible for investigating and processing complaints against health care providers. The Task Force concluded that establishing a specialized division, responsible for only health care, would strengthen DPR's ability to ensure that health care providers met acceptable standards. *Id.*

150. *Id.* at 44-47.

151. *Id.* at 43-44.

152. *Id.* at 39-40.

153. *Id.* at 46. *See also* Kussorow, Handley & Yessian, *An Overview of State Medical Discipline*, 257 J. A.M.A. 820, 823 (1987) (arguing that the clear and convincing evidentiary standard for physician discipline is an impediment to regulation of physician competency).

4. *Redistribution of Insurance Costs*

The fourth major Task Force proposal is a plan providing liability insurance premium assistance to selected physicians. Entitled the Premium Impact Equity Plan,[154] this scheme would provide a subsidy to physicians who demonstrate substantial financial hardship due to liability insurance costs.[155] Physicians would be eligible for the proposed subsidy if their incomes fell below a predetermined figure and if they paid more than a specified percentage of their gross medical practice revenues on liability insurance.[156] Eligibility for premium subsidization also would be dependent on the physician meeting specified performance standards such as an absence of prior medical malpractice paid claims or disciplinary actions.[157]

The proposal recommends that a state agency, financed by a surcharge on medical malpractice premiums, administer the premium subsidies.[158] The amount of the premium subsidy to eligible physicians would be the amount necessary to bring the percentage of gross revenues spent on liability premiums down to specified levels.[159] The Task Force's stated goal in recommending the Premium Impact Equity Plan is to promote health care availability by providing assistance to physicians who might otherwise be unable to establish a medical practice in the state, such as the young practitioner in a high-risk specialty practicing in a medically underserved area.[160]

5. *Negative Recommendations*

In addition to the proposals outlined above, the Task Force considered and recommended against legislative adoption of several reforms. Specifically, the Task Force recommended against adoption of reforms that limit a plaintiff's right to recover damages while requiring the plaintiff to prove fault. Included in this category are the Medical Incident Compensation Act and a constitutional amendment limiting noneconomic damages in all cases.[161] The Task Force reasoned that

---

154. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 50-56.

155. *Id.* at 51.

156. *Id.*

157. *Id.* The Task Force did not recommend values for the income figure or the figure for excessive proportionate cost of liability insurance. *Id.*

158. *Id.* at 53.

159. *Id.* at 52.

160. *Id.* at 13-14. Examples include obstetrics, orthopedics, and neurosurgery.

161. *Id.* at 34-35. The Medical Incident Compensation Act (MICA) would have limited a plaintiff's economic damages and totally eliminated noneconomic damages. The proposed constitutional amendment would have limited recovery of noneconomic damages in all tort cases to $100,000. *Id.* This proposed amendment appeared as Amendment 10 on the November 1988 ballot and was rejected by the voters. *See* Anderson, *Yes to English, No to Amendment 10*, Miami Herald, Nov. 9, 1988, at 1A, col. 3.

such proposals limit the rights of injured plaintiffs without distinguishing meritorious from nonmeritorious claims.[162] Additionally, these proposals do nothing to reduce the transaction costs of the civil justice system.

The final negative recommendations are in the area of liability insurance reform. First, the Task Force rejected the suggestion that physician's liability insurance premiums be subsidized by general tax revenues.[163] Second, it rejected proposals providing liability premium relief to physicians in high-risk specialties by increasing the cost of liability insurance to physicians in low-risk specialties. The Task Force concluded that such schemes, called risk class compression plans, create excessive governmental intrusion into the private insurance market. In addition, risk compression plans have the potential to create the anomaly of high-risk, high-income physicians being subsidized by low-risk, lower-income, physicians.[164]

III. Reaching a Legislative Consensus

Although the 1986 Legislature initiated a thorough review of the tort system, rising rates and threatened withdrawal of medical malpractice insurers from the state provided the impetus for further legislative action. However, the two houses of the Legislature were at odds as to the primary cause of the crisis, and therefore, as to the ways of resolving the problems, even on a temporary basis.

Following the lead of Insurance Commissioner Bill Gunter, the House in the 1987 Regular Session looked to insurance industry pricing standards as a means of providing relief to physicians who pay the larger malpractice premiums.[165] Generally known as the "mandatory pooling plan," the House proposal recommended that the majority of low-risk physicians who pay substantially lower premiums partially subsidize the premiums paid by the minority of physicians who practice in high-risk specialties.[166] This would be accomplished by requiring all insured physicians to purchase primary coverage from a state insurance fund and by establishing a maximum differential in premiums. The House proposal would have permitted the highest rate to

---

162. Task Force Recommendations, *supra* note 50, at 35.

163. *Id.* at 50.

164. *Id.* at 50-51.

165. Fla. CS for HB 1458, § 2 (1987) (First Engrossed). The legislation also provided for a lower standard of care in emergency room situations. *Id.* § 3.

166. *Id.* § 2. The House Insurance Committee predicted that high-risk specialists would receive a rate reduction of 25% to 40%. Premiums of low-risk physicians were expected to remain at the then-present levels, but could rise slighty. Staff of Fla. H.R. Comm. on Ins., CS for HB 1458 (1987) Staff Anaysis 3 (final July 21, 1987) (on file with committee).

be no greater than five times the lowest rate,[167] rather than the tenfold differential currently encountered by neurosurgeons and similar specialists.[168] The cost of subsidization would be offset to some degree by savings resulting from having the insurance system operated by the state on a nonprofit basis.[169]

The Senate in 1987 did not adopt a formal position, although generally it was accepted that a 1985 bill supported by the Florida Medical Association, commonly known by the acronym "MICA" (Medical Incident Compensation Act),[170] had substantial support in the upper chamber.[171] This proposal would compensate individuals injured by medical malpractice on a scheduled basis similar to that employed under workers' compensation statutes.[172] Although initially touted as a no-fault proposal, MICA would require at least a substantial showing that the injury resulted from actual malpractice, arguably requiring the same level of proof required under general tort law.[173]

As the close of the 1987 Regular Session approached, it was clear that a compromise would not be reached. The likelihood of calling a special session to address the medical malpractice problems became immediately apparent. Accordingly, concurrent with the study of the Task Force, two groups were appointed in Tallahassee to prepare for the special session on medical malpractice. The Speaker of the House appointed an ad hoc House committee chaired by Representative Carl Ogden,[174] the Chairman of the Committee on Insurance. Representative Hamilton Upchurch,[175] the Chairman of the Committee on Judici-

---

167. Fla. CS for HB 1458, § 2 at 9, lines 12-18 (1987) (First Engrossed) (proposed amendment to FLA. STAT. § 627.351(4)(d) (Supp. 1986)).

168. *See* TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 27. In 1987, rates for family physicians and neurological surgeons in Dade and Broward Counties for medical malpractice insurance coverage of $1 million per claim/$3 million annual aggregate were $19,415 and $192,420, respectively.

169. The proposed bill would prohibit the paying of sales commissions and exempt the premiums from application of premium taxes. *See* Fla. CS for HB 1458, § 2 at 10, line 20 and at 13, lines 1-3 (1987) (First Engrossed).

170. Fla. SB 1030 (1985).

171. This perception, however, may have been erroneous. Senator John Vogt, Dem., Cocoa Beach, 1972-1988, cosponsor of the 1985 MICA bill, and Senate President during the 1987 Regular Session, indicated that he would not support the MICA proposal unless it was the only solution the Legislature could achieve. Huard, *Vogt: Doctors May Strike to Force Legislative Action*, Palm Beach Post, Aug. 29, 1987, at 10A, col. 2.

172. *See* Fla. CS for HB 1458, § 2 (1987) (First Engrossed).

173. *Id.* § 1, at 2, lines 18-24. "In any action . . . the claimant shall have the burden of proving by the greater weight of the evidence that the alleged actions of the health care provider represented a breach of the accepted standard of care for that health care provider." *Id.*

174. Dem., Jacksonville, 1968-1987.

175. Dem., St. Augustine, 1978-1988.

ary, served as Vice-Chairman.[176] At the same time, a joint legislative/executive committee, commonly known as the Governor's Working Group, was created and charged with finding a consensus position on medical malpractice reforms for submission to the Legislature at the special session. It consisted of four members of the House, four members of the Senate, and four people representing the Governor and was chaired jointly by Representative Ogden and Senator Dempsey Barron.[177] The failure to agree on the appointment of a single chairman is indicative of the wide divergence of opinion on the scope of and solutions to problems with medical malpractice insurance and the tort system.

Although the House previously endorsed legislation that created the medical malpractice insurance pool,[178] strong opposition from the insurance industry and the Florida Medical Association eroded enthusiasm for the proposal among the members of the House. Accordingly, when the ad hoc House committee considered the various proposals, at least ten plans were presented to it.[179] Formal consideration of all of the proposals did not occur, however, since the absence of some Democratic members and a boycott by some Republican members prevented the convening of a quorum. Nevertheless, a review of several of the major proposals submitted by members and various interest groups before the Task Force released its recommendations provides significant insight into the options available to the Legislature.

A. The Early Legislative Proposals

Along the lines of prior Senate proposals, two substantially different versions of a workers' compensation-type system of compensating

---

176. Other committee members are Representatives Mike Abrams, Dem., Miami (Chairman, Committee on Health Care); Sam Bell, Dem., Ormond Beach, 1974-1988 (Chairman, Committee on Appropriations); Jim Burke, Dem., Miami (Speaker Pro Tempore); Carl Carpenter, Dem., Plant City (Chairman, Committee on Rules); Peter Dunbar, Repub., Crystal Beach, 1978-1988 (Chairman, Minority Policy Committee); Bud Gardner, Dem., Titusville, 1978-1988 (Chairman, Committee on Finance & Taxation); Elaine Gordon, Dem., North Miami; Tom Gustafson, Dem., Ft. Lauderdale (Speaker-Designate); Mary Ellen Hawkins, Repub., Naples; Fred Lippman, Dem., Hollywood (Chairman, Committee on Regulatory Reform); Dale Patchett, Repub., Vero Beach (Minority Leader); John Renke, Repub., New Port Richie (Minority Floor Whip); Art Simon, Dem., Miami; and Dave Thomas, Repub., Englewood.

177. The Governor's Working Group consisted of Cochairmen Senator Dempsey Barron, Dem., Panama City, 1960-1988, and Representative Ogden; Senators Mattox Hair, Dem., Jacksonville, 1974-1988; Toni Jennings, Repub., Orlando; Curt Kiser, Repub., Palm Harbor; and Representatives Burke, Carpenter, and Patchett; and Gregory Coler (Secretary, Department of Health); Amy Baker (Director of Legislative Affairs); Bill Bryant (Special Counsel to the Governor); and Larry Polivka (Policy Coordinator for Health and Human Services).

178. Fla. CS for HB 1458 (1987).

179. The various proposals are on file with the House Insurance Committee.

medical injuries were submitted. A plan authored by Representative Ron Glickman[180] recommended a strictly no-fault program which would provide an administrative hearing to allow a person to recover for any injury arising from the provision or failure to provide medical care.[181] Although the plan would allow recovery for noneconomic damages, total recovery would be capped at $450,000 unless the plaintiff proves by clear and convincing evidence that a greater amount is warranted.[182] In contrast, the Florida Medical Association recommended a fault-based system which would compensate only injuries arising from malpractice, and would limit damages on a scheduled basis similar to that provided for in workers' compensation injuries.[183] A form of noneconomic damages would be awardable under this plan but the maximum amount would be $100,000. The Florida Medical Association's plan was substantially similar to the MICA plan supported by Senator Barron during the 1985 Regular Session.[184]

Representative Glickman proposed a second alternative which would cap physician liability at $500,000 per occurrence, with excess judgments recoverable against a state-funded plan.[185] However, Representative Art Simon,[186] one of the major forces behind the 1985 Medical Malpractice Act and the 1986 Insurance and Tort Reform Act, submitted a less costly program. Under Representative Simon's plan, noneconomic damages would be capped at $250,000, and total damages would be capped at $1,000,000.[187] Excess judgments would be recoverable from the Legislature by a special act if the plaintiff established entitlement to compensation in excess of the proposed limits.[188] Additionally, the proposal would create a state-funded subsidy of medical malpractice premiums for amounts in excess of ten percent of gross medical practice revenues,[189] and it would require hospitals to indemnify physicians for suits arising from emergency care provided

---

180. Dem., Tampa.

181. H.R. Preliminary Draft 97-37-8-7, § 6, at 11, lines 8-11 (1987) (on file with Fla. H.R. Comm. on Ins.).

182. *Id.* § 7, at 11-12.

183. Florida Medical Association Draft 3-563A-85 (Draft 1), § 2, at 11 (Aug. 12, 1987) (on file with Fla. H.R. Comm. on Ins.). The bill would require the plaintiff to establish a "breach of the prevailing professional standard of care." *Id.* § 1, at 2, lines 5-9.

184. *See* Fla. SB 1030 (1985).

185. H.R. Preliminary Draft 97-40A-9-7 (1987) (on file with Fla. H.R. Comm. on Ins.).

186. Dem., Miami.

187. H.R. Preliminary Draft 242-157-8-7 (Sept. 9, 1987) (on file with Fla. H.R. Comm. on Ins.).

188. *Id.* § 2, at 7, lines 12-22. Representative Simon also proposed a constitutional amendment authorizing these limitations. *See* Proposed Fla. HJR (Sept. 10, 1987) (unnumbered) (proposing the creation of FLA. CONST. art. 1, § 24) (on file with Fla. H.R. Comm. on Ins.).

189. *Id.* § 1, at 2-3.

to trauma patients.[190] A third proposal, presented by Representative Ron Silver,[191] the House Majority Leader, recommended a cap of $1,000,000 for damage awards against physicians or hospitals who participate in the Premium Assurance Plan.[192] Representative Silver's plan would eliminate punitive damage awards in medical malpractice actions[193] and would provide premium subsidies to hospitals that actively provide indigent and Medicaid treatment, and to physicians who actively provide Medicaid treatment.[194]

Representative Ogden and Insurance Commissioner Gunter suggested creating a mandated state-sponsored insurance program with a limitation on premium differentials similar to the 1987 House legislation.[195] This legislation was intended to expire within three years, because by that time it was assumed that the 1985 and 1986 reforms would have stabilized the private insurance market.[196] However, the mandatory state insurance program was rejected by the Task Force in its final recommendations on medical malpractice.[197]

An ad hoc committee composed of nine physicians and nine attorneys practicing in Palm Beach County presented one of the most interesting proposals.[198] This proposal, commonly referred to as the Palm Beach Plan, recommended creation of a state-run insurer in which participation of all physicians would be mandated.[199] Unlike the other proposals for mandatory state-run insurance plans, premiums for the first $250,000 of coverage would not be subject to any limitation under this plan, other than actuarial soundness.[200] Excess coverage for indemnities between $250,000 and $2,000,000 would be paid equally by all physicians with an estimated cost of $3,500 per physician.[201] The Palm Beach Plan also would reduce judgments by the

190. *Id.* § 13, at 19.

191. Dem., North Miami Beach.

192. H.R. Preliminary Draft 117-180-8-7, § 1, at 1-2 (1987) (on file with Fla. H.R. Comm. on Ins.).

193. *Id.*

194. *Id.* § 3, at 5.

195. Preliminary Draft by Rep. Ogden, § 1, at 5 (Sept. 9, 1987) (on file with Fla. H.R. Comm. on Ins.); Preliminary Draft by Dep't. of Ins., § 2, at 8 (Sept. 1, 1987) (on file with Fla. H.R. Comm. on Ins.).

196. Preliminary Draft by Dep't. of Ins., § 2, at 10 (Sept. 1, 1987) (on file with H.R. Comm. on Ins.).

197. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 3.

198. *See* letter and accompanying proposal (Palm Beach Plan) from Theodore Babbitt, attorney and member of the ad hoc committee, to Rep. Carl Ogden (Aug. 14, 1987) (on file with Fla. H.R. Comm. on Ins.) [hereinafter Palm Beach Plan].

199. *Id.* Palm Beach Plan at 1.

200. *Id.*

201. *Id.*

amount of any payments received from collateral sources, such as workers' compensation, health insurance, or automobile liability insurance, and would eliminate the right of such insurers to subrogation of medical malpractice recoveries.[202]

The provisions for which the Palm Beach Plan became most known are the variations on provisions included in the 1985 Medical Malpractice Act.[203] While the 1985 Act required pre-suit investigations by both plaintiffs and defendants and encouraged the parties to obtain expert medical opinions,[204] the Palm Beach Plan would go further. For example, under this plan it would be prima facie evidence of bad faith litigation when the plaintiff failed to obtain the required written expert opinion before notifying each defendant of the intention to initiate litigation, or when the defendant did not receive a corresponding written expert opinion prior to denying the claim.[205] The Palm Beach Plan would give the court the authority to dismiss a claim or strike a defense if it is found that the action or answer was filed without good cause,[206] and it would expand the arbitration provisions of the 1985 Act which permitted the defendant to offer to arbitrate upon an admission of liability.[207] Under the 1985 provisions, if the defendant admits liability, the defendant may opt for binding arbitration and the plaintiff would be required to arbitrate rather than litigate.[208] Although not enacted, the Palm Beach Plan served as the basis for some of the recommendations of the Task Force.

With the collapse of the House ad hoc committee, the burden of finding a starting point for the Legislature rested primarily with the Governor's Working Group and the Task Force. The Task Force issued its recommendations to the Governor's Working Group and after much deliberation they were accepted as the starting point for the Legislature.[209] The task of refining and implementing the recommendations was left to the Legislature.

---

202. *Id.* at 2.

203. These include recommendations on pre-suit screening and arbitration. Of particular interest is the recommendation that both the plaintiff and defendant obtain written medical opinions and the proposed two-tiered arbitration proceeding in which the plaintiff participates in establishing the amount of damages, but the allocation of responsibility is arbitrated only among the defendants. *See id.* at 2-4.

204. *See* FLA. STAT. § 768.57 (1987).

205. Palm Beach Plan, *supra* note 198, at 2.

206. *Id.* at 3.

207. *Id.*

208. FLA. STAT. § 768.57(3)(b)(3) (1985).

209. *See* letter from Sen. Barron and Rep. Ogden, Cochairmen of the Governor's Working Group, to Gov. Bob Martinez, Rep. Jon Mills and Sen. John Vogt (Jan. 14, 1988) (on file with Fla. H.R. Comm. on Ins.).

B. *Refining the Task Force Proposals in the Special Session*

The effort to implement the recommendations of the Task Force in the House was spearheaded by Representative Sam Bell,[210] who wrote the legislation that established the Task Force in 1986.[211] Although significant variations were included, the Task Force's recommendations served as an outline for Representative Bell's proposal in the 1988 Special Session of the Legislature. For example, Representative Bell's proposal suggested subsidies only to physicians practicing in medical manpower shortage areas in lieu of a statewide premium equity plan.[212] The bill also addressed the issue of emergency care by redefining the standard of care to which a patient is entitled when receiving trauma care or emergency care.[213] The concept to assure plaintiffs full recovery of all damages in arbitration also was altered by Representative Bell's proposal. Under this variation, where only some defendants agree to arbitrate, the arbitrators selected by the defendants would allocate damages among all defendants, including those not in arbitration, and the arbitrating defendants would be responsible only for payment of their pro rata share.[214]

Although the proposed legislation was discussed at several hearings prior to the special session,[215] the task of either amending or rejecting the legislation was left for the committee meetings and floor debate scheduled for the special session. The Senate proposal[216] was referred to only one substantive committee,[217] whereas the House proposal[218] was referred to the Insurance and Judiciary Committees and ultimately to the Appropriations Committee, which is chaired by the proposal's principal sponsor, Representative Bell.[219] Concurrently, the House Regulatory Reform Committee considered the portion of the

---

210. Dem., Ormond Beach, 1974-1988.

211. Representative Bell sponsored the original legislation creating the Task Force. *See* Fla. HB 565 (1986). The language passed as part of the 1986 Tort Reform and Insurance Act. Ch. 86-160, § 63, 1986 Fla. Laws 695, 756.

212. Fla. HB 7-E, § 1, at 28-34 (1988).

213. *Id.* § 1, at 52-57.

214. *Id.* § 1, at 25. *But see id.* at 22 (providing that all defendants are jointly and severally liable for all of the plaintiff's damages).

215. The House Committee on Insurance considered drafts of the legislation on January 6, 1988, and January 21, 1988. The House Committee on Judiciary considered drafts in workshop on January 28, 1988 (drafts on file with Fla. H.R. Comm. on Ins. and Fla. H.R. Comm. on Judiciary).

216. Fla. SB 6-E (1988).

217. FLA. S. JOUR. 4 (Spec. Sess. Feb. 2, 1988). The bill also was referred to the Senate Appropriations Committee. *Id.*

218. Fla. HB 7-E (1988).

219. FLA. H.R. JOUR. 5 (Spec. Sess. Feb. 2, 1988).

legislation that addressed the regulation of health care professionals.[220]

Many of the concerns of the Insurance Committee had been addressed previously. Nevertheless, the committee members submitted nearly 150 proposed amendments, approximately 100 of which were sponsored by Representative Simon.[221] The Insurance Committee, however, did not adopt any major policy changes. The bill was reported to the Judiciary Committee[222] where Representative Simon, who was also a member of the Judiciary Committee, reoffered several amendments which had been either defeated or were not considered by the Insurance Committee.[223]

The legislation which left the Judiciary Committee differed substantially from that recommended by the Task Force, Representative Bell, and the Insurance Committee.[224] Few provisions remained unchanged. A proposal supported by trial lawyers which provided mandatory nonbinding arbitration of all medical malpractice cases without damage limitations replaced the voluntary binding arbitration provision that limited damages.[225] The premium assistance plan no longer applied to areas of medical manpower shortage, but rather provided a subsidy to each physician who paid in excess of ten percent of gross income for medical malpractice insurance.[226] A higher burden of proof of the prevailing professional standard of care and a good faith defense replaced the gross negligence standard of care for emergency treatment delivered at a trauma center,[227] proposed by Representative Bell.[228] The bill requested the Supreme Court of Florida to adopt new standard jury instructions to address the exigencies of emergency treatment.[229] The bill required obstetricians to participate in the Florida Birth-Related Neurological Injury Compensation Association.[230] Additional funding would be raised by assessing abortion clinics $50 per abortion[231] in addition to the hospital assessment of $50 per

220. *Id.* at 6. Fla. HB 11-E (1988) (this bill contains the same regulatory provisions as Fla. HB 7-E (1988)).

221. Proposed amendments on file with the House Committee on Insurance.

222. FLA. LEGIS., HISTORY OF LEGISLATION, 1988 SPECIAL SESSION E, HISTORY OF HOUSE BILLS at 797, HB 7-E.

223. Proposed amendments on file with the House Committee on Judiciary.

224. *See* Fla. CS for HB 7-E (1988).

225. *Id.* § 1, at 19-20.

226. *Id.* at 26-32.

227. *Id.* at 51-53.

228. *See supra* notes 210-14 and accompanying text.

229. *Id.* § 51, at 128-29.

230. *Id.* § 1, at 44.

231. *Id.* at 45.

birth,[232] and by increasing the contribution of obstetricians from $5,000 to $30,000 over a period of five years.[233] Amendments also were approved to prohibit coercion of hospital employees relating to testimony in malpractice cases,[234] and extending the statute of limitations an additional year for the purpose of adding defendants.[235] Essentially, only the pre-suit screening and regulation of the medical professions remained intact.

The bill was reported out of the Judiciary Committee as Committee Substitute for House Bill 7. The amendments were incorporated overnight and the Appropriations Committee heard the bill the following morning. With the exception of the coercion amendment, the Appropriations Committee reversed the Judiciary Committee amendments and returned the legislation essentially to the version adopted by the Insurance Committee.[236] The standard of care issue, however, was readdressed on the floor of the House, where the "reckless disregard" standard for emergency care again was rejected in favor of a requirement of proving by clear and convincing evidence the breach of the prevailing professional standard of care, coupled with a good faith defense. Unlike the amendment adopted by the Judiciary Committee, the standard applied to all emergency care delivered in hospitals or trauma centers.[237]

While the House legislation underwent substantial review and revision, the Senate legislation[238] was referred only to the sponsoring Commerce Committee and the Appropriations Committee.[239] The Senate legislation, as proposed by the Commerce Committee and approved by the Appropriations Committee, was comparatively limited in that it did not include any provisions relating to the birth-related neurological injury plan or the premium subsidies for physicians.[240] Consistent with the House legislation, the bill addressed the regulation of the medical profession and pre-suit screening of claims by both plaintiffs and defendants.[241] Also it provided additional limited immunity for emergency rooms or trauma centers, although at a different

232. *Id.* at 44.
233. *Id.* at 45.
234. *Id.* § 5, at 63.
235. *Id.* § 50, at 128.
236. *See* FLA. H.R. JOUR. 12-24 (Spec. Sess. Feb. 3, 1988) (amendments to Fla. CS for HB 7-E (1988), sponsored by the Comm. on Approp.).
237. *See id.* at 22.
238. Fla. SB 6-E (1988).
239. FLA. S. JOUR. 4 (Spec. Sess. Feb. 2, 1988).
240. *See* Fla. CS for SB 6-E (1988).
241. *Id.* The provisions were similar in scope and philosophy, but the language varied.

standard than that provided in the House legislation.[242] Rather than voluntary binding arbitration, the bill called for mandatory nonbinding arbitration of all medical malpractice claims with sanctions for unreasonable requests for a trial de novo.[243] Finally, the bill limited noneconomic damages in all medical malpractice claims to $250,000, absent clear and convincing evidence that an award above the cap is not excessive.[244]

The victory of the trial lawyers in convincing the Senate committees to approve nonbinding rather than binding arbitration was shortlived. The full Senate adopted the proposal of the Task Force recommending voluntary binding arbitration with contingent caps on noneconomic damages.[245] The Senate also removed the automatic across-the-board cap on noneconomic damages,[246] a provision which had been opposed at least as vehemently by the trial lawyers as the Task Force arbitration plan.

When the bills were sent to conference, the two chambers agreed in only two areas: the prompt resolution of meritorious claims (pre-suit screening and arbitration) and enhanced regulation of the health care industry. The House and Senate agreed to change the standard of care in emergency rooms, but did not agree on the applicable standard. The House had approved a premium subsidy plan for certain medical personnel and the no-fault compensation plan for birth-related neurological injuries; the Senate had rejected both of those proposals. The special session was scheduled to end the following day and the conferees did not meet until the next morning. The only decision that had been made was that the Senate bill would be the vehicle for amendment because the Senate version passed before the House version.

Following short preliminary discussions, the Senate conferees agreed to accept a no-fault compensation plan for birth-related injuries if the House conferees agreed to drop the premium subsidy proposals.[247] Additionally, the conferees committed themselves to seek a compromise position on the standard of care in emergency room

---

242. *Id.* § 42, at 70. The standard of "reckless, but not conscious disregard" was amended on the Senate floor to read "conscious disregard, or reckless disregard, whether conscious or not." *Id.* § 42, at 70 (First Engrossed). The final House position required that the breach of the prevailing professional standard of care be proven by clear and convincing evidence and included a "good faith" defense for the health care provider. Fla. CS for HB 7-E, § 1, at 57 (1988) (First Engrossed).

243. Fla. CS for SB 6-E, § 44 (1988).

244. *Id.* § 45.

245. *See* FLA. S. JOUR. 8-10 (Spec. Sess. Feb. 3, 1988).

246. *Id.*

247. Conference Comm. on Fla. CS for SB 6-E, tape recording of proceedings (Feb. 4, 1988) (on file with Fla. H.R. Comm. on Commerce) [hereinafter Conference Comm. Tapes].

situations.[248] The House language on arbitration and pre-suit screening was adopted, and the Senate language on professional regulation was adopted.[249] Staff was directed to return with a working draft to be used by the conferees at a later meeting at which further amendments would be considered.[250] Without having an opportunity to fully read the revised document,[251] conference committee members agreed to recommend it as the final conference report with only three minor amendments: two relating to the doctrine of joint and several liability in cases involving teaching hospitals, and one requiring that all Florida licensed physicians, whether or not practicing in the state, pay the physician assessment for the Florida Birth-Related Neurological Injury Compensation Plan.[252] The three amendments were inserted and the conference committee members returned to sign the report. The committee adopted the proposed conference committee report unanimously.[253]

One of the defeated amendments deleted a provision which purported to limit the liability of arbitrating physicians and hospitals to the policy limits of their respective insurance coverages.[254] Upon learning that the amendment failed and that the Assistant Executive Director of the Task Force believed that the amendment was needed to improve the likelihood of sustaining the constitutionality of the prompt resolution of claims provisions, the Speaker of the House notified the conferees that he did not intend to reconvene the House—which would effectively kill the entire proposal. The conferees then agreed to reconvene and adopt an amendment which clarified their intention that the proposal would apply only to insurers and not to the insured health care providers.[255] The final conference recommendation passed that evening.[256]

---

248. *Id.*

249. *Id.*

250. *Id.*

251. Because of editing and printing delays, the document was not available before the committee reconvened.

252. Conference Comm. Tapes, *supra* note 247. The amendment relating to the physician assessments provided an estimated additional funding source of $1.6 million. *Id.*

253. *Id.*

254. Whether the language was intended to apply to defendants or to their insurers is unclear.

255. *See* ch. 88-1, § 54(3), 1988 Fla. Laws 119, 169 (codified at FLA. STAT. § 766.207(3) (Supp. 1988)). "The liability of any insurer shall be subject to any applicable insurance policy limits." *Id.*

256. The House adjourned after brief remarks, and the medical malpractice special session came to a close. FLA. H.R. JOUR. 65 (Spec. Sess. Feb. 4, 1988).

IV. PROMPT RESOLUTION OF CLAIMS

The most controversial proposals submitted by the Task Force were those relating to the prompt resolution of meritorious claims. Although representing an extension of concepts adopted by the Legislature in 1985, the differences between the Task Force recommendations and the 1985 legislation were viewed as among the most substantial tort reform ever considered by the Florida Legislature. The reforms were assailed by both the plaintiffs' bar and the defense bar as unworkable;[257] criticized by physicians as being too lenient for plaintiffs;[258] and criticized by public interest groups as representing an unwarranted deprivation of citizen rights.[259] Thus, they served as the primary lightning rod for attacks on the Task Force's proposals.

The proposal for prompt resolution of meritorious claims can be divided into two basic concepts.[260] First, plaintiffs and defendants must be prevented from filing unwarranted claims and defenses.[261] Second, both parties should be encouraged to submit meritorious claims to arbitration to avoid the emotional and financial costs of litigation and the uncertainty of jury verdicts.[262] To accomplish these goals, the Task Force recommended, and the Legislature adopted, a revised version of the Palm Beach Plan.[263]

As justification for the adoption of the prompt resolution proposals, the Legislature adopted various findings made by the Task Force.[264] These included a determination that rapidly rising insurance premiums are increasing the cost of medical care and threatening the availability of quality medical care; that the primary cause of increas-

---

257. Representatives of the Trial Lawyers' Section of The Florida Bar, The Academy of Florida Trial Lawyers, and The Florida Defense Lawyers' Association, questioned whether the arbitration program would be used by any parties and suggested that the caps on damages would violate the Florida Constitution. Fla. H.R., Comm. on Ins., tape recording of proceedings (Jan. 21, 1988) (tapes on file with Comm. on Ins.); Governor's Working Group, tape recording of proceedings (Jan. 7, 1988) (tapes on file with H.R. Comm. on Ins.).

258. Although the concept was generally supported by physicians, the President of the Florida Medical Association suggested that the proposed cap on noneconomic damages was too high. *See* Academic Task Force for Review of the Insurance and Tort Systems, transcript of conference proceedings 72-74 (Oct. 29, 1987) (testimony of Dr. James White, Pres., Fla. Med. Assoc.).

259. Governor's Working Group tape, *supra* note 257.

260. Ch. 88-1, § 48(2), 1988 Fla. Laws 119, 164 (codified at FLA. STAT. § 766.201(2) (Supp. 1988)).

261. *Id.* § 48(2)(a)(1), 1988 Fla. Laws at 164 (codified at FLA. STAT. § 766.201(2)(a)(1) (Supp. 1988)).

262. *Id.* § 42(2)(b)(1) (1988), 1988 Fla. Laws at 164 (codified at FLA. STAT. § 766.201(2)(b)(1) (Supp. 1988)).

263. For a description of the Palm Beach Plan, see *supra* notes 198-208 and accompanying text.

264. *See* ch. 88-1, § 48, 1988 Fla. Laws 119, 164 (codified at FLA. STAT. § 766.201 (Supp. 1988)).

ing premiums is the increase in loss payments; that submission of claims to arbitration reduces costs; and that full recovery of economic losses, such as lost wages, represents an unnecessary windfall for plaintiffs since damages are not subject to taxation.[265]

To achieve the goal of early resolution of meritorious claims, legislation was passed to both prevent frivolous litigation and to provide a system of voluntary binding arbitration.[266] Unlike prior attempts to discourage frivolous litigation, the 1988 provisions mandate investigation by all parties and provide a method of verifying the opposing party's compliance.[267] Unlike previous attempts to encourage arbitration, the 1988 legislation provides specific financial incentives to both parties in addition to the general incentives of decreasing delay and litigation costs.[268]

The starting point for the 1988 legislative attempt to discourage litigation of frivolous suits and suits where liability is clear was the 1985 legislation which required a plaintiff to mail notice of intent to initiate litigation to each defendant at least ninety days prior to filing a malpractice complaint.[269] When adopted in 1985, the ninety-day period was intended to provide the defendant or the insurance company an opportunity to investigate the claim and, when appropriate, to seek an amicable settlement prior to the filing of a suit.[270] The statute encouraged, but did not require, the defense to obtain a medical opinion as one of the methods of complying with the investigation requirement. The 1985 Act did not require the plaintiff to conduct an investigation prior to mailing the notice of intent to initiate litigation, recognizing the plaintiff's relatively weak position in discovering the essential evidence needed to pinpoint the tortious act or failure to act which resulted in injury.[271] This is because the plaintiff is often not in a

265. *Id.*

266. Ch. 88-277, §§ 30-35, 1988 Fla. Laws 1422, 1476 (codified at FLA. STAT. §§ 766.207-.209, .21, .211, .212 (Supp. 1988)).

267. Although the 1985 Medical Malpractice Act required an investigation by all parties, the 1988 provisions require each party to obtain a verified written medical expert opinion. Failure to obtain such an opinion is readily verifiable. *Compare* ch. 88-277, § 26, 1988 Fla. Laws 1422, 1473 (codified at FLA. STAT. § 766.203 (Supp. 1988)) *with* FLA. STAT. §§ 768.495, .57 (1985).

268. Ch. 88-277, § 30, 1988 Fla. Laws 1422, 1476 (codified at FLA. STAT. § 766.207 (Supp. 1988)).

269. FLA. STAT. § 768.57 (1985).

270. The defendant could avoid the filing of a claim in the judicial system by admitting liability and offering to arbitrate damages if the plaintiff would agree to a limitation on non-economic damages. Although the amount of the damage limitation was not provided, the defendant was permitted to set a limit in the offer. *See id.* § 768.57(3)(b)(3).

271. The statute required the plaintiff's counsel to conduct a reasonable investigation prior to filing the action. *See, e.g.*, FLA. STAT. § 768.495(1) (1985) (requiring the attorney filing the action to make a "reasonable investigation as permitted by the circumstances").

position to determine which parties should be held responsible for the injury.

In addressing this issue, the Task Force determined that a need existed for investigation by both the plaintiff and the defendant, and that the plaintiff's investigation should be completed before the notice of intent to initiate litigation is mailed to the defendant.[272] However, the Task Force did not recommend the methodology to be employed by plaintiffs in conducting the investigation, although it did suggest that a written medical opinion corroborating the claim should be required.[273] In speaking to the discovery problems, the Task Force merely stated that "[t]his proposal would include procedures for allowing both claimant and the defendant to have reasonable access to information within the possession or control of the other party in order to evaluate the claim."[274] The 1985 Act already required the plaintiff to submit to a physical examination and to provide the defendant discoverable information without the requirement of formal discovery.[275] Accordingly, the only issue left to be addressed was the extent to which the plaintiff could pursue discovery.

It was clear that if a system could be devised which enables the plaintiff to obtain the necessary evidence prior to mailing the notice of intent to initiate litigation, the involvement of unnecessary defendants in the litigation could be avoided. Likewise, with the information obtained from the pre-suit investigation, settlement offers could be more intelligently evaluated by the plaintiff. On the other hand, legislation permitting discovery prior to filing a complaint may be unduly burdensome on defendants and thereby negate the objective of protecting defendants from the costs of unwarranted claims. As a compromise between protecting the right of the plaintiff to receive essential information and protecting a potential unnamed defendant from burdensome intrusion, the legislation permits discovery of all medical records, but does not require defendants to submit to questioning in the form of interrogatories or depositions or other forms of pretrial discovery.[276] This limited discovery may be sufficient to permit a medical expert to make an initial diagnosis as to the probable cause of an

---

272. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 16.

273. *Id.* at 19.

274. *Id.*

275. *See* FLA. STAT. § 768.57 (1985).

276. Ch. 88-277, § 27, 1988 Fla. Laws 1422, 1474 (codified at FLA. STAT. § 766.204 (Supp. 1988)). The plaintiff also is entitled to informal discovery following the mailing of the notice of intent to intiate litigation. The additional discovery will assist the plaintiff in evaluating a defendant's settlement offer or offer to arbitrate. *See id.* § 28, 1988 Fla. Laws at 1475 (codified at FLA. STAT. § 766.205 (Supp. 1988)).

injury where the records are inconclusive. However, an argument may be made that the requirement of obtaining a corroborating written medical expert opinion deprives a plaintiff of the constitutional right of access to the courts.[277]

In conjunction with the requirement that the plaintiff obtain an expert opinion prior to mailing the notice of intent to initiate litigation,[278] the 1988 malpractice reforms also require a defendant to obtain an opinion prior to denying the claim. The opinion obtained by the defendant must corroborate the existence of "reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury."[279] This opinion may be based on either a finding that the injury did not result from negligence or that the defendant did not perform in a negligent manner and that the injury resulted from the negligence of a party other than the defendant.

The 1988 Act also provides authority for the court either to dismiss the claim or to strike a defense where the requirements of pre-suit investigation, including the obtaining of written corroboration by a medical expert, have not been met.[280] Additionally, sanctions may be imposed against the offending party, or the offending party's counsel, whichever is appropriate.[281] The sanctions include both attorney's fees and costs incurred during the pre-suit investigation.[282] The legislation provides for such relief to be granted in response to a motion filed subsequent to the completion of the pre-suit investigation.[283] But, since neither the claim nor the defense would be before the court, it is likely that the court would not entertain such motions prior to the filing of the complaint or the response.

Where the court finds that an attorney failed to conduct a proper pre-suit investigation, the court is directed to report the attorney to

---

277. FLA. CONST. art. I, § 21. The law merely requires, however, that the opinion state that there are "reasonable grounds to support the claim of medical negligence." Ch. 88-277, § 26, 1988 Fla. Laws at 1473 (codified at FLA. STAT. § 766.203 (Supp. 1988)). Where the records are inconclusive, a medical expert could, in good faith, determine that "reasonable" grounds exist. Additional discovery is provided to both the plaintiff and the defendant after the notice of intent to initiate litigation is mailed. *Id.* § 28, 1988 Fla. Laws at 1475 (codified at FLA. STAT. § 766.205 (Supp. 1988)). The statute of limitation is tolled for 90 days following the mailing of the notice of intent to initiate litigation. FLA. STAT. § 768.57(4) (1987).

278. Ch. 88-277, § 26, 1988 Fla. Laws 1422, 1473 (codified at FLA. STAT. § 766.203 (Supp. 1988)).

279. *Id.*

280. *Id.* § 29, 1988 Fla. Laws at 1475 (codified at FLA. STAT. § 766.206 (Supp. 1988)).

281. *Id.* § 29(2)-(3), 1988 Fla. Laws at 1475 (codified at FLA. STAT. § 766.206(2)-(3) (Supp. 1988)).

282. *Id.*

283. *Id.* § 29(1), 1988 Fla. Laws at 1475 (codified at FLA. STAT. § 766.206(1) (Supp. 1988)).

The Florida Bar for disciplinary review.[284] To discourage medical experts from expressing unsupported opinions, the courts are directed to report any medical expert who issues an opinion not supported by reasonable investigation. Such reports are to be made to the Division of Medical Quality Assurance or a similar regulatory agency in the state in which the expert is admitted to practice.[285] If an expert is disqualified by a court at least three times for issuing an unsupported opinion, any court may refuse to consider future expert testimony provided by that expert.[286]

As the Legislature approached the special session on medical malpractice, support existed for the development of an arbitration alternative tailored to medical malpractice claims. Prior to the 1988 Special Session, three separate mechanisms for arbitration of a medical malpractice claim were available:[287] (1) The court could require both parties to submit to nonbinding arbitration of the entire claim;[288] or (2) the parties could agree to binding arbitration of the entire claim;[289] or (3) if the defendant was willing to admit liability, the defendant could offer voluntary binding arbitration limited to the issue of damages.[290] Despite the existence of these provisions, the Legislature entertained new proposals for the arbitration of medical malpractice cases.

The Trial Attorneys' Section of the Florida Bar recommended a specific arbitration system for medical malpractice cases.[291] The proposal is modeled after a mandatory nonbinding arbitration plan used in the United States District Court for the Middle District of Florida. In many respects this plan is similar to the provisions of section 44.303, Florida Statutes, except that the court is required to refer a medical malpractice case to nonbinding arbitration, and the imposition of sanctions for requesting a trial de novo are more limited.[292] In contrast to the Bar proposal, the Palm Beach Plan suggested manda-

284. *Id.* § 29(4), 1988 Fla. Laws at 1476 (codified at FLA. STAT. § 766.206(4) (Supp. 1988)).

285. *Id.* § 29(5), 1988 Fla. Laws at 1476 (codified at FLA. STAT. § 766.206(5) (Supp. 1988)).

286. *Id.*

287. *See* FLA. STAT. §§ 44.303-.304, 768.57, .575 (1987).

288. *Id.* §§ 44.303, 768.575.

289. *Id.* § 44.304.

290. *Id.* § 768.57.

291. *See* Governor's Working Group, tape recording of proceedings (Jan. 14, 1988) (tapes on file with H.R. Comm. on Ins.).

292. Under the Florida Bar Proposal, the plaintiff requesting a trial de novo would have to obtain a judgment of only 75% of the arbitration award to avoid sanctions. However, the defendant requesting a trial de novo would have to avoid a judgment in excess of 125% of the arbitration award to avoid sanctions. Under section 44.303(5), Florida Statutes (1987), sanctions are assessed if the party requesting a trial de novo does not obtain a more favorable result than the arbitration decision.

tory binding arbitration where the defendant agrees to pay all damages without regard to fault.[293]

The Task Force, however, recommended a voluntary binding arbitration provision that is voluntary for all parties.[294] As in the Palm Beach Plan, a defendant wishing to arbitrate would be required to waive any defenses (although the Task Force recommendation, unlike the Palm Beach Plan, does not require an admission of guilt). Thus, the arbitration is limited to the issue of damages. In other respects, however, the Task Force recommendation is significantly different from both the Palm Beach Plan and the 1985 Act.

The basic premise behind the arbitration plan submitted by the Task Force is that parties will agree to arbitrate only if sufficient incentives exist to waive a jury trial on liability and damages. While the medical malpractice binding arbitration provisions adopted by the Legislature in 1985 offered the plaintiff the incentive to arbitrate in order to avoid having to prove liability, the only clear incentive offered to the defendant was to save trial costs and to avoid the uncertainty of a jury verdict. The defendant could condition the offer to arbitrate and admit liability on an agreement by the plaintiff to limit recovery for noneconomic damages;[295] but if accepted by the plaintiff, it is unlikely that the arbitration award would compensate the plaintiff for economic losses after the legal fees are paid.[296] Where liability is clear, the incentive to the plaintiff would be of little value.[297] Likewise, where liability is unclear, the defendant's incentives would be diminished.[298] The Task Force, therefore, sought to include incentives which apply to a wider range of cases and which are economically more compelling for all parties.

The Task Force recommendation adopted by the Legislature provides a package of incentives and disincentives for both plaintiffs and defendants.[299] Like the 1985 Act, plaintiffs are offered the incentive of

---

293. For a detailed account of the Palm Beach Plan, see *supra* notes 198-208 and accompanying text.

294. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 21.

295. FLA. STAT. § 768.57(3)(b)(3) (1987).

296. While noneconomic damages are awarded to compensate the plaintiff for pain and suffering, loss of companionship, and similar losses, generally it is recognized that plaintiff's counsel is paid from noneconomic damages.

297. If the plaintiff fails to negotiate a favorable settlement in such cases, the jury still may award noneconomic damages in an amount equal to what would have been awarded in arbitration.

298. Any savings in litigation costs must be weighed against the probability that a settlement, discounting actual damages, can be achieved.

299. Ch. 88-277, §§ 30, 32, 1988 Fla. Laws 1422, 1476, 1479 (codified at FLA. STAT. §§ 766.207, .209 (Supp. 1988)).

recovering damages without having to prove liability.[300] Additionally, a plaintiff who agrees to arbitrate is entitled to recover attorney's fees up to a maximum of fifteen percent of the total recovery,[301] which under most contingency contracts is approximately one-half of the plaintiff's fees.[302] The plaintiff also is encouraged to offer arbitration which was not permitted under the 1985 Act;[303] if the offer to arbitrate is refused by the defendant, the plaintiff is entitled to attorney's fees equal to twenty five percent of the award at trial and prejudgment interest.[304] The major disincentive for a plaintiff to accept or offer arbitration is the limitation on noneconomic damages of $250,000.[305] The defendant also retains the incentive of reduced litigation costs that the 1985 Act provided. More importantly, defendants are assured that if they accept an offer to arbitrate, or a plaintiff accepts the defendant's offer, noneconomic damages cannot exceed $250,000.[306] If a defendant's offer is refused, noneconomic damages at trial are capped at $350,000.[307] These damage caps were opposed by a representative of the Palm Beach ad hoc committee.[308] In permitting any party to initiate an offer to arbitrate,[309] the Task Force proposal varies from the 1985 Act's arbitration provisions and the Palm Beach Plan, both of which limit that option to the defendant.[310] Procedurally, the plaintiff and defendant may make the offer at any time within ninety days following, or in conjunction with, the mailing of the notice of intent to initiate litigation.[311] If the offer is not accepted within thirty days, it is considered rejected, except that the defendant may accept the offer at any time prior to, or in conjunction with, the response to the notice of intent,[312] which is due within ninety days.[313]

---

300. *See id.* § 30, 1988 Fla. Laws at 1476 (codified at FLA. STAT. § 766.207 (Supp. 1988)).

301. *Id.*

302. For maximum fee schedules in contingency fee contracts, see FLA. BAR RULES OF PROF. CONDUCT 4-1.5(F).

303. *See* FLA. STAT. § 768.57 (1985). The offer to arbitrate may only be made in the defendant's response to the notice of intent to initiate litigation. *Id.*

304. Ch. 88-277, § 32(3), 1988 Fla. Laws 1422, 1480 (codified at FLA. STAT. § 766.209(3) (Supp. 1988)).

305. *Id.* § 30(7), 1988 Fla. Laws at 1477 (codified at FLA. STAT. § 766.207(7) (Supp. 1988)).

306. *Id.*

307. *Id.* § 32(4), 1988 Fla. Laws at 1480 (codified at FLA. STAT. § 766.209(4) (Supp. 1988)).

308. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 5.

309. Ch. 88-277, § 30(2), 1988 Fla. Laws 1422, 1476 (codified at FLA. STAT. § 766.207(2) (Supp. 1988)).

310. *See* FLA. STAT. § 768.57(3) (1987); *see also* letter and accompanying proposal from Theodore Babbitt, *supra* note 198.

311. Ch. 88-277, § 30(2), 1988 Fla. Laws 1422, 1476 (codified at FLA. STAT. § 766.207(2) (Supp. 1988)).

312. *Id.* § 30(3), 1988 Fla. Laws at 1477 (codified at FLA. STAT. § 766.207(3) (Supp. 1988)).

313. FLA. STAT. § 768.57(3)(b) (1987).

Under the arbitration procedures adopted in 1988, initial arbitration of the total amount of damages is conducted by a panel of three arbitrators: one is a hearing officer assigned by the Division of Administrative Hearings; one is selected by the plaintiffs; and one is selected by the defendants.[314] The state hearing officer is designated as the chief arbitrator[315] and as the person with the authority to determine legal issues such as the admissibility of evidence.[316] The evidence code applicable to the Administrative Procedures Act[317] also is designated as the applicable code in the arbitration proceedings.[318] The defendants are responsible for paying the two privately-selected arbitrators,[319] either at an agreed amount or in accordance with a fee schedule established by the appropriate circuit court.[320]

In cases involving multiple defendants, an arbitration panel establishes the amount of damages; then, a second arbitration panel (consisting of the hearing officer and two arbitrators selected by the defendants) assigns degrees of fault to each defendant.[321] Damages assessed against any defendant not participating in arbitration may be recovered by the participating defendants in an action for contribution.[322] However, once the participating defendants pay the total amount of the arbitration award, they may be subject to a contribution action brought by any defendant who did not participate in the arbitration proceeding.[323]

The initial arbitration panel is responsible for determining if the plaintiff is entitled to compensatory damages, and if so, in what amount.[324] Net economic damages must be awarded including past and future medical expenses, loss of earning capacity, and eighty percent of lost wages, less collateral source payments such as unemploy-

---

314. Ch. 88-277, § 30(4), 1988 Fla. Laws 1422, 1477 (codified at FLA. STAT. § 766.207(4) (Supp. 1988)).

315. *Id.*

316. *Id.* § 30(7)(l), 1988 Fla. Laws at 1478 (codified at FLA. STAT. § 766.207(7)(l) (Supp. 1988)).

317. FLA. STAT. § 120.58(1)(a) (1987).

318. Ch. 88-277, § 30(10), 1988 Fla. Laws 1422, 1478 (codified at FLA. STAT. § 766.207(10) (Supp. 1988)).

319. *Id.* § 30(7)(g), 1988 Fla. Laws at 1478 (codified at FLA. STAT. § 766.207(7)(g) (Supp. 1988)).

320. *Id.* § 30(6), 1988 Fla. Laws at 1422 (codified at FLA. STAT. § 766.207(6) (Supp. 1988)).

321. *Id.* § 31, 1988 Fla. Laws at 1478 (codified at FLA. STAT. § 766.208 (Supp. 1988)). If a hospital is one of the defendants, a hospital risk manager must serve as one of the two arbitrators appointed by the defendants. If the defendants cannot agree on the selection of arbitrators, the Director of the Division of Administrative Hearings appoints them from lists submitted by the defendants. *Id.*

322. *Id.* § 31(6), 1988 Fla. Laws at 1479 (codified at FLA. STAT. § 766.208(6) (Supp. 1988)).

323. *Id.* § 31(5), 1988 Fla. Laws at 1479 (codified at FLA. STAT. § 766.208(5) (Supp. 1988)).

324. *Id.* § 30(7), 1988 Fla. Laws at 1477 (codified at FLA. STAT. § 766.207(7) (Supp. 1988)).

ment compensation and insurance recoveries for which no right of subrogation exists.[325] Noneconomic damages, on the other hand, are strictly limited[326] by a cap of $250,000 "calculated on a percentage basis with respect to capacity to enjoy life."[327] Accordingly, where the plaintiff suffers only a fifty percent loss of capacity, noneconomic damages must be no greater than $125,000.[328] The total amount of noneconomic damages awarded to multiple claimants cannot exceed $250,000.[329] While not addressed in the legislation, presumably where the total of noneconomic damages for multiple claimants exceeds $250,000, the amount recoverable is prorated for each of the claimants. For example, if two claimants each sustain $150,000 in noneconomic damages, each would recover only $125,000 in noneconomic damages. In keeping with the concept of not placing the issue of liability before the arbitration panel, the legislation prohibits an award of punitive damages.[330]

The second arbitration panel is responsible for allocating among various defendants the damages awarded by the first panel. This panel may allocate a portion to a nonparticipating defendant,[331] but as discussed below, such allocation will not affect the ability of the plaintiff to recover the full amount of damages from the participating defendants.

Once the Legislature selected the arbitration program recommended by the Task Force, rather than that recommended by the trial attorneys, two major issues remained. First, the determination of the application of the doctrine of joint and several liability was considered in committee.[332] Second, the extent to which a defendant may be held liable for damages in excess of the applicable policy limits was not resolved until the final moments of the 1988 Special Session.

As part of the 1986 Tort Reform Act, the Legislature modified the application of the doctrine of joint and several liability by exempting noneconomic damages from its scope.[333] Although the attempt to

---

325. *Id.* § 30(7)(a), 1988 Fla. Laws at 1477 (codified at FLA. STAT. § 766.207(7)(a) (Supp. 1988)).

326. *Id.* § 30(7), 1988 Fla. Laws at 1477 (codified at FLA. STAT. § 766.207(7) (Supp. 1988)).

327. *Id.* § 30(7)(b), 1988 Fla. Laws at 1477 (codified at FLA. STAT. § 766.207(7)(b) (Supp. 1988)).

328. *Id.*

329. *Id.*

330. *Id.* § 30(7)(d), 1988 Fla. Laws at 1477 (codified at FLA. STAT. § 766.207(7)(d) (Supp. 1988)).

331. *Id.* § 31(4), 1988 Fla. Laws at 1479 (codified at FLA. STAT. § 766.208(4) (Supp. 1988)).

332. The application of the doctrine of joint and several liability was clarified in the House by an amendment adopted in the Appropriations Committee.

333. *See* FLA. STAT. § 768.81 (1987).

abolish the doctrine failed in 1986, substantial support for its abolition remained.[334] Health care practitioners argued that as a further incentive for their participation in the arbitration alternative, the doctrine should not apply in arbitration. Initially, Representative Bell, the primary sponsor of the House legislation, adopted this position.[335] However, the arbitration program adopted by the Legislature prohibits the plaintiff from participating in the allocation proceedings.[336] This raised the concern that defendants might shift the damage award to either those defendants who are judgment-proof or to those not participating in the arbitration process.[337] This ability of the defendants to limit their liability in a proceeding in which the plaintiff is not allowed to participate raises substantial due process concerns. Thus, a compromise approach was reached: apply the doctrine of joint and several liability to the total arbitration award, including noneconomic damages.[338] Applying the doctrine of joint and several liability to noneconomic damages in arbitration proceedings is a retreat from the 1986 Tort Reform Act.[339] However, to be fully understood, it must be viewed in light of the fact that noneconomic damages are limited in arbitration and the plaintiff is prohibited from participating in the alloction proceedings. In this respect, both the House and the Senate bills were philosophically in agreement.

A further attempt to limit the plaintiff's ability to recover in arbitration arose from what initially seemed to be an innocuous provision in the House proposal which was intended to apply to insurers.[340] In early drafts of Representative Bell's proposal, the term "defendant"

---

334. In the House, eight Democratic committee chairmen cosponsored legislation in 1988 to completely abolish the doctrine of joint and several liability. *See* Fla. HB 591 (1988).

335. The bill sponsored by Representative Bell would have required each defendant to be responsible for only a pro rata share of the damages awarded in arbitration. Fla. HB 7-E, § 1, at 25 (1988).

336. Plaintiffs do not participate in the allocation proceedings. *See* ch. 88-277, § 31, 1988 Fla. Laws 1422, 1478 (codified at FLA. STAT. § 766.208 (Supp. 1988)).

337. This is especially true since the nonarbitrating defendants lack standing to object to the introduction of evidence relating to their contribution to the injury. Theoretically, the arbitration panel could allocate the total responsibility against the nonarbitrating defendants.

338. *See* ch. 88-277, § 31(4), 1988 Fla. Laws 1422, 1478 (codified at FLA. STAT. § 766.208(4) (Supp. 1988)). Since the plaintiff is entitled to full recovery from the arbitrating defendants regardless of the allocation decision, arguably the plaintiff is deprived of neither a property right in the award nor of any right to redress by the prohibition of the opportunity to participate in the allocation phase.

339. *See* FLA. STAT. § 768.81(5) (1987) (applying the doctrine of joint and several liability only to economic damages except where the total damages do not exceed $25,000).

340. Fla. CS for HB 7-E, § 1, at 20, lines 20-28 (1988) (First Engrossed). "Such acceptance [to arbitrate the dispute] . . . shall be a binding commitment to comply with the decision of the arbitration panel, *subject to any applicable insurance policy limits.*" *Id.* (emphasis added).

was defined to include the defendant's insurer.[341] Insurers were concerned that agreeing to arbitrate might imply an agreement to pay amounts in excess of coverage because the legislation limits the defendant's liability to the amount of the policy limits. The bill also provides that the insurer cannot submit to arbitration without the consent of the insured in recognition of the insured's liability for any excess award.[342] To clarify its intent, the House Insurance Committee amended the limitation provision to apply specifically to insurers rather than to defendants.[343] However, the House Judiciary Committee deleted the entire provision and rejected voluntary binding arbitration in favor of the mandatory nonbinding arbitration proposal sponsored by the Bar.[344] The binding arbitration provisions were reinserted by the House Appropriations Committee and the limitation was inadvertantly reinserted with the term "defendant" rather than "insurer," which is the form in which it was adopted by the House.[345] The error was not discovered until the House bill passed and the issue was submitted to a joint conference committee.

Believing that the reinsertion of the term "defendant" was accidental, Representative Upchurch offered an amendment to the conference committee which deleted the limitation.[346] This amendment was supported by staff of the Task Force which expressed the opinion that the limitation was constitutionally suspect and would further discourage the use of arbitration by plaintiffs.[347] The Florida Medical Association, however, strongly supported the limitation as a means of encouraging physicians to agree to arbitrate to protect personal assets. The amendment offered by Representative Upchurch was defeated.[348] The

---

341. *See, e.g.*, Fla. H.R. Draft 251-179E-12-7, § 1, at 9 (1988) (on file with Fla. H.R. Comm. on Judiciary).

342. Fla. CS for HB 7-E, § 1, at 23, lines 24-26 (1988) (First Engrossed).

343. Fla. H.R. Comm. on Ins., Amendment 24 to Fla. HB 7-E (1988) (Feb. 2, 1988) (on file with committee).

344. *See* Fla. CS for HB 7-E (1988).

345. FLA. H.R. JOUR. 12 (Spec. Sess. Feb. 3, 1988).

346. Conference Comm. Tapes, *supra* note 247.

347. *Id.* (discussion by Donald G. Gifford, Ass't Exec. Dir. of the Task Force). To the extent that the legislation would prohibit a plaintiff from recovering economic damages in arbitration, including necessary medical care, the bill would place the plaintiff in the economic position of having to refuse arbitration and proceed to trial with a limitation on noneconomic damages. If the plaintiff cannot afford to arbitrate, the legislation would remove a remedy without providing commensurate benefits as required under Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987), and Kluger v. White, 281 So. 2d 1 (Fla. 1973). While the proposal submitted by the Task Force limited noneconomic damages in arbitration, it provided for payment of a portion of the plaintiff's legal fees, and eliminated the necessity of proving liability. Additionally, the limitation on noneconomic damages at trial applied only where the plaintiff was unwilling to go to arbitration. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 21-24.

348. Conference Comm. Tapes, *supra* note 247.

amendment's defeat in conference was significant because the product of a conference committee cannot be amended by either body once adopted.[349] The conference committee report was adopted unanimously and the meeting concluded.[350]

Before the conference report was presented to either chamber of the Legislature, House Speaker Jon Mills[351] learned that the committee failed to pass Representative Upchurch's amendment. Since he was aware of the limitation's potential constitutional problems, the Speaker was determined that the conference report would not be brought before the House prior to expiration of the special session. He insisted that the provision limiting a physician's liability for economic damages be deleted or no malpractice reform would pass. In an unprecedented action, the conferees reconvened, reversed their position and passed a clarifying amendment, which applied the limitation on liability only to insurers rather than to named defendants.[352] A plaintiff who agrees to arbitration is now assured of full recovery of the damages awarded, within the boundaries of the bill's other limitations, except where a defendant proves to be insolvent.

V. FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PLAN

The Task Force proposed "adoption of legislation allowing physicians and hospitals to participate in a no-fault plan limited to birth-related neurological injuries."[353] Although not the most sweeping of reforms because of its limited application, the introduction of no-fault as a viable alternative to common tort law in a field other than workers' compensation is in itself a fairly revolutionary concept.

The plan forwarded to the Legislature was commonly referred to as the Virginia Plan.[354] Although not yet implemented,[355] the Virginia no-fault system for compensating certain severely handicapped infants offers the promise of decreasing the burden medical malpractice suits place on obstetricians, with the objective of lowering their relatively high premiums. In commending the plan to the Legislature, the Task Force stated:

---

349. FLA. H.R. RULE 6.59.

350. Conference Comm. Tapes, *supra* note 247.

351. Dem., Gainesville, 1978-1988.

352. *See* ch. 88-1, § 54(3), 1988 Fla. Laws 119, 169 (codified at FLA. STAT. § 766.207(3) (Supp. 1988)).

353. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 1.

354. The recommendation is modeled after the Virginia Birth-Related Neurological Injury Compensation Act, VA. CODE ANN. §§ 38.2-5000 to -5021 (1988).

355. The Act became effective January 1, 1988. *See, e.g., id.* § 38.2-5002.

> [O]bstetricians were among the physicians most severely affected by current medical malpractice problems. Obstetricians were more likely than other physicians to have claims filed against them, their malpractice premiums were among the highest and the recent increases in malpractice premiums for obstetricians were greater than for other physicians. The [Task Force's] Fact-Finding Report specifically noted that in today's society, anything other than a normal birth is considered an aberration and often leads to a claim against the obstetrician.[356]

While the Task Force estimated medical malpractice insurance costs for physicians in general to be 11.6% of gross practice revenues in 1986-1987,[357] the premiums of obstetricians & gynecologists were estimated to represent 23.1% of their gross practice revenues.[358] The 1986-1987 mean annual premium of $72,439 for obstetricians represents more than a 500% increase from the mean premium of $11,983 for Florida obstetricians in 1981-1982.[359] As a percentage of gross revenues, the malpractice premiums for obstetricians rose from 5.5% to 23.1% during the same five-year period.[360]

The Virginia Plan offers potential savings to obstetricians in two ways. First, by removing certain cases from the arena of medical malpractice, the premiums theoretically should decrease. Second, the plan requires each licensed physician to contribute to the plan,[361] as well as hospitals providing maternity services who wish to receive the immunity provided,[362] thus spreading the burden for financing the compensation for the birth-related injuries.

The debate over the Virginia Plan centered on the fact that the plan had not yet been tested. The Legislature generally agreed that the premiums faced by obstetricians were particularly oppressive and reports of decreasing availability of obstetrical services caused significant concern.[363] Therefore, rather than oppose outright the provisions of the Virginia Plan, opponents argued for a delayed implementation. They cautioned that the Legislature should not adopt a plan which offered, but might not deliver, savings to obstetricians. If compensa-

---

356. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 31.
357. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 237.
358. *Id.*
359. *Id.*
360. *Id.*
361. VA. CODE ANN. § 38.2-5019(A)(3) (1988).
362. *Id.* § 38.2-5019(A)(2).
363. In a survey of Florida physicians, 26% of those who offered obstetrical services terminated that part of their practice. *See* TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 248-49.

ble injury was defined too broadly, a significant number of infants who would not recover damages under the tort system might find recovery here. That could mean that the additional compensation paid under the Virginia Plan may outweigh any savings experienced by obstetricians in malpractice premiums. In the Senate, these arguments, coupled with concerns about the funding mechanism, were used successfully to remove the Virginia Plan from consideration.[364]

Florida's version of the Virginia Plan proposed to fund the no-fault compensation by requiring contribution of $250 per licensed physician or osteopath,[365] a $50 per birth contribution by hospitals,[366] and an additional contribution of $4,750 from each obstetrician wishing to be covered.[367] If these contributions are insufficient, each casualty insurer would be assessed an amount equal to 0.25% of net direct premiums written.[368] Assuming full participation of all obstetricians, the funding would approach $22,250,000 annually.[369]

The plan adopted in Virginia provides compensation only for infants suffering an injury to the brain or spinal cord caused by a mechanical failure or deprivation of oxygen.[370] The injury must be so severe as to leave the child permanently nonambulatory, incontinent, unable to communicate, and in need of assistance in all aspects of life.[371] Virginia authorities estimated that the definitions would cover approximately forty infants per year.[372] In Florida, however, the concern was that the definition was so restrictive that it would include

---

364. *See* Fla. SB 6-E (1988); Fla. CS for SB 6-E (1988); Fla. CS for SB 6-E (1988) (First Engrossed).

365. Ch. 88-277, § 39(4)(b), 1988 Fla. Laws 1422, 1485 (codified at FLA. STAT. § 766.314(4)(b) (Supp. 1988)).

366. *Id.* § 39(4)(a), 1988 Fla. Laws at 1484 (codified at FLA. STAT. § 766.314(4)(a) (Supp. 1988)).

367. *Id.*

368. *Id.* § 39(5)(c), 1988 Fla. Laws at 1486 (codified at FLA. STAT. § 766.314(5)(6) (Supp. 1988)).

369. Letter from Jerome F. Vogel, Actuary, Fla. Dep't of Ins., Bureau of Rates, to Pamela Birch Fort, Staff Dir., S. Comm. on Commerce (Jan. 11, 1988) (on file with Fla. H.R. Comm. on Ins.).

370. VA. CODE ANN. § 38.2-5001 (1988).

> *"Birth-related neurological injury"* means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living. This definition shall apply to live births only.

Id.

371. *Id.*

372. No-Fault Compensation for Neurologically Impaired Infants: An Exploration of the Issues for the Insurance Panel, Harv. Sch. of Pub. Health 15 (Oct. 7, 1987) (on file, *Florida State University Law Review*).

very few infants. If this concern proves true, the definition defeats the entire purpose for establishing the plan.

In response to the concerns raised over the restrictive definition, Representative Bell, along with other sponsors of the House legislation, recommended extending the Virginia Plan to include infants receiving a permanent and substantial mental and physical disability.[373] This definition would cover approximately sixty infants per year according to a closed claim study by the Department of Insurance.[374] However, a study based on birth data from the Department of Health and Rehabilitative Services suggests that the definition would include approximately 180 births.[375] If premature births were omitted, the number of covered infants would be reduced to sixty, the same estimate as the Department of Insurance.[376] Assuming coverage of sixty infants per year, the Department of Insurance estimated total costs of approximately $45 million annually.[377] The Senate had reasonable concerns with the costs, since this figure was double the estimated revenue provided in the first year.[378] To cover 180 infants, the annual costs were expected to reach $135 million,[379] leaving an annual deficit in excess of $100 million.

The House passed a substantially underfunded Virginia-type plan which covered even premature infants suffering substantial permanent mental and physical disability.[380] The Senate proposed no plan at all. Thus, the conference committee had to resolve the differences. The solution was to pare down the program and to find a funding source other than state general revenue dollars.

The first part of the solution was relatively simple. By removing premature infants from eligibility for compensation under the program, the cost estimates were returned to the $45 million range, one-third the cost of the program approved by the House.[381] The second part also was easily achieved. With the agreement of Insurance Commissioner Gunter, the House appropriated $40 million from the Insur-

373. Fla. HB 7-E, § 24(2) (1988).

374. Letter from Jerome F. Vogel, *supra* note 369.

375. Letter from John S. Curran, M.D., Acting Chairman, Dep't of Pediatrics, College of Medicine, Univ. of S. Fla., to Robert Henderson, Staff Counsel, Fla. H.R. Comm. on Ins. (Feb. 2, 1988) (on file with Fla. H.R. Comm. on Ins.).

376. *Id.*

377. Letter from Jerome F. Vogel, *supra* note 369.

378. *Id.*

379. This estimate assumes that the cost per incident will remain constant where coverage for 180 infants is provided rather than coverage for 60 infants.

380. Fla. CS for HB 7-E (1988) (First Engrossed).

381. Letter from John S. Curran, *supra* note 375. By removing coverage for premature babies, Dr. Curran estimated that the plan would cover only 60 infants. *Id.*

ance Commissioner's Regulatory Trust Fund to subsidize the premiums of physicians who practice in areas where there is a shortage of the specialty provided by the physician.[382] The House conferees approved this recommendation, but the Senate rejected any premium subsidy plans.[383] After agreeing with the Senate not to adopt the premium subsidy provisions, the House conferees agreed to a proposal by Senator Mattox Hair[384] to use the $40 million Trust Fund money as a backup for the Birth-Related Neurological Injury Compensation Fund,[385] $20 million of which was placed in the fund prior to the implementation of the program.[386] The remaining $20 million would be available as needed.[387] The initial financial viability of the program appeared to be guaranteed.

To provide adequate financing of the fund in future years, the compromise legislation provided that assessments of obstetricians, other physicians, and hospitals be increased proportionately each year in accordance with a determination by the Department of Insurance as to the amount of funds required to assure actuarial soundness of the fund.[388] By requiring actuarially sound proportional increases and mandating continuing assessments against hospitals and physicians, the plan is designed to avoid the problems that occurred with the Florida Patients' Compensation Fund.[389] However, hospitals and other physicians may find themselves funding a higher proportion of unfunded liabilities if the plan allows obstetricians to withdraw.[390]

Under the plan, a claim may be brought on behalf of an infant against the Florida Birth-Related Neurological Injury Compensation Association (Association)[391] by filing a claim with the Division of

---

382. Fla. CS for HB 7-E, § 18, at 29-30 (1988) (First Engrossed).

383. *See* Fla. CS for SB 6-E (1988) (First Engrossed).

384. Dem., Jacksonville, 1974-1988.

385. Conference Comm. Tapes, *supra* note 247.

386. Because of a drafting error, the first $20 million would not have been transmitted until January 1, 1990, rather than January 1, 1989. *See* ch. 88-1, § 76(4), 1988 Fla. Laws 119, 184. *See also* FLA. STAT. § 766.314(5)(b) (Supp. 1988).

387. *See* FLA. STAT. § 766.314(5)(b) (Supp. 1988).

388. Ch. 88-277, § 39(7)(b), 1988 Fla. Laws 1422, 1487 (codified at FLA. STAT. § 766.314(7)(b) (Supp. 1988)).

389. Initial rates charged by the Patients' Compensation Fund were substantially inadequate, resulting in significant assessments of participants to cover the shortfall. *See* Comment, *Medical Malpractice in Florida: Prescription For Change*, 10 FLA. ST. U.L. REV. 593, 598 (1983).

390. The Legislature did not address the manner in which any future unfunded liability would be financed. It is unclear whether the Insurance Commissioner can increase assessments for a current year to pay unfunded liabilities from prior years.

391. Ch. 88-277, § 40(1)(a), 1988 Fla. Laws 1422, 1487 (codified at FLA. STAT. § 766.315(1)(a) (Supp. 1988)). The Florida Birth-Related Neurological Injury Compensation Association is an independent entity; it is neither a state board, commission nor agency. It is gov-

Workers' Compensation in the Department of Labor.[392] Recovery under the plan is the exclusive remedy for injuries that qualify. Recovery in tort is prohibited not only in relation to the obstetrician, but also against all other parties to the extent that the claim involves the injury.[393] Although the claim must name any hospital or physician involved in the birth, neither the hospital nor the physician are parties to the action.[394]

Upon receipt of the claim by the Division of Workers' Compensation, the Association is served with a copy of the claim and is provided forty-five days in which to submit "relevant written information relating to the issue of whether the injury alleged is a birth-related neurological injury."[395] Discovery by both the Association and the claimant is permitted in the form of interrogatories and depositions.[396]

Following receipt of the petition, the deputy commissioner must set a date for the hearing no less than sixty nor more than 120 days from the date of filing.[397] During that period, the claim must be reviewed by a medical advisory panel consisting of a neurosurgeon, an obstetrician, and a pediatrician.[398] At least ten days prior to the scheduled date of the hearing, the panel is required to report its finding as to whether the injury qualifies as a compensable injury, i.e., whether the injury resulted from mechanical failure or oxygen deprivation, and whether the injury resulted in the child becoming substantially and permanently mentally and physically disabled, requiring assistance in all aspects of life.[399] At least one member of the panel is required to be available to testify at the hearing.[400] Although the deputy commissioner must consider the panel's finding, the finding is not binding.[401]

Following the hearing, the deputy commissioner must determine if the injury is birth-related.[402] If the injury was caused by oxygen depri-

---

erned by a board of directors consisting of five people appointed by the Insurance Commissioner with each director serving for a term of three years. Of the five members, one represents obstetricians, one represents casualty insurers, one represents hospitals, one represents other physicians, and one is a citizen representative. Nominees are recommended by the respective trade associations, but the Insurance Commissioner is not bound by the recommendations.

392. Ch. 88-1, § 64, 1988 Fla. Laws 119, 175 (codified at FLA. STAT. § 766.305 (Supp. 1988)).

393. Ch. 88-277, § 37, 1988 Fla. Laws 1422, 1483 (codified at FLA. STAT. § 766.303 (Supp. 1988)).

394. *See* ch. 88-1, § 66(2), 1988 Fla. Laws 119, 177 (codified at FLA. STAT. § 766.307(2) (Supp. 1988)).

395. *Id.* § 64(3), 1988 Fla. Laws at 176 (codified at FLA. STAT. § 766.305(3) (Supp. 1988)).

396. *Id.* § 66(3), 1988 Fla. Laws at 177 (codified at FLA. STAT. § 766.307(3) (Supp. 1988)).

397. *Id.*

398. *Id.* § 67, 1988 Fla. Laws at 177 (codified at FLA. STAT. § 766.308 (Supp. 1988)).

399. *Id.*

400. *Id.*

401. *Id.*

402. *Id.* § 68(1)(a), 1988 Fla. Laws at 177 (codified at FLA. STAT. § 766.309(1)(a) (Supp. 1988)).

vation or mechanical failure, and resulted in the required physical and mental deprivations, the injury is presumed to have been birth-related, and a party who disagrees with the presumption has the burden of proving that the injury occurred at a time other than during the birthing process.[403] The deputy commissioner must also determine whether obstetrical services were provided by a participating physician[404] and the amount of compensation to be awarded.[405] Appeal of the decision of the deputy commissioner may be made to the district court.[406]

Compensation for the infant under the no-fault plan is limited to actual expenses for medically necessary and reasonable care including medical, hospital, custodial, residential, and rehabilitative care. Actual expenses are limited to medically necessary drugs, special equipment, and related travel.[407] Additionally, periodic or lump-sum payments may be awarded to the parents or legal guardians in an amount not to exceed $100,000.[408] Expenses relating to the filing of the claim, including attorney's fees, also may be recovered.[409]

The compensation provisions were amended twice at the suggestion of Representative Upchurch during the conference committee to reduce the cost of the program and to protect against a probable constitutional challenge. The plan, as enacted in Virginia and passed by the Florida House, would provide a minimal wage recovery for the infant who survives to adulthood. The wage recovery would be payable from the time of the infant's eighteenth birthday until he or she turns sixty-five.[410] The plan did not provide any funding to the parents as compensation for their lost derivative actions. The conferees replaced the

---

403. *Id.* § 68(2), 1988 Fla. Laws at 178 (codified at FLA. STAT. § 766.309(2) (Supp. 1988)).

404. *Id.* § 68(1)(a)(2)(b), 1988 Fla. Laws at 178 (codified at FLA. STAT. § 766.309(1)(a)(2)(b) (Supp. 1988)). If the obstetrical services are delivered by a physician who did not pay the voluntary additional assessment, the injury is not covered and the child may pursue a claim for negligence through the normal tort system. Since most hospitals are required to pay an assessment regardless of whether the obstetrician who delivered the child participates in the program, it is likely that most hospitals will require membership in the Association as a condition to maintaining or obtaining staff privileges as an obstetrician. *Id.*

405. *Id.* § 68(1)(c), 1988 Fla. Laws at 178 (codified at FLA. STAT. § 766.309(1)(c) (Supp. 1988)).

406. *Id.* § 70, 1988 Fla. Laws at 179 (codified at FLA. STAT. § 766.311 (Supp. 1988)).

407. *Id.* § 69(1), 1988 Fla. Laws at 178 (codified at FLA. STAT. § 766.31(1) (Supp. 1988)). The amount awarded is to be decreased by certain recoveries from collateral sources including governmental support and health insurance.

408. *Id.* § 69(1)(b), 1988 Fla. Laws at 179 (codified at FLA. STAT. § 766.31(1)(b) (Supp. 1988)).

409. *Id.* § 69(1)(c), 1988 Fla. Laws at 179 (codified at FLA. STAT. § 766.31(1)(c) (Supp. 1988)).

410. Under the Virginia Act, as well as the Florida House Proposal, the child is entitled to receive 50% of the average weekly wage from age 18 until 65. *See* VA. CODE ANN. § 38.2-5009(3) (1988); Fla. CS for HB 7-E, § 32(1)(b), at 44, lines 8-18 (1988) (First Engrossed).

wage provision with a provision allowing compensation for the parent or legal guardian, recognizing that the anticipated life span for many of the infants may be short, but that the loss to the parent would be long term.[411] This change has the effect of placing the funds with the infant's guardian at an earlier period. If the guardian invests these funds, they are likely to produce a greater return than the lost wages would have produced.[412] The second modification was intended to permit the deputy commissioner to arrange for the placement of the child in a state facility rather than in a more expensive private facility where residential treatment is required.[413] The amendment, however, referred to custodial treatment rather than residential treatment.[414] Custodial treatment is not provided in state-designated facilities, and thus the amendment did not have its intended effect.

If the claim is denied, the claimant may proceed with an action at law in accordance with the provisions governing medical negligence actions. The filing of a claim against the Association tolls the statute of limitations for any medical malpractice action during the pendency of the claim and during appeal.[415] Although no provision is made for tolling the time in which a claim may be filed for recovery under the no-fault plan during the pendency of a medical malpractice claim, a seven-year limitation is provided,[416] as opposed to the hybrid two-, four-, or seven-year statute of limitations applicable to malpractice actions.[417]

The finding of the deputy commissioner that the injury is not a birth-related neurological injury is binding upon the obstetrician, thus prohibiting this as a defense in a subsequent tort proceeding relating to the injury.[418] The legislation, however, does not specify that the finding is binding upon other health care practitioners. If the court finds the injury is a birth-related neurological injury, but the deputy commissioner reaches a different conclusion, theoretically the plaintiff

411. The conference committee members were advised that the average anticipated life span for children covered by the Virginia Plan is seven years. Since the definition used in Florida is intended to be less restrictive, the information received relating to the Virginia Plan may be inapplicable.

412. At present, 50% of the average weekly wage in Florida produces an income of less than $9,000 annually.

413. *See* ch. 88-1, § 69(1)(a), 1988 Fla. Laws 119, 178 (codified at FLA. STAT. § 766.31(1)(a) (Supp. 1988)).

414. *Id.*

415. *Id.* § 65, 1988 Fla. Laws at 176 (codified at FLA. STAT. § 766.306 (Supp. 1988)).

416. Ch. 88-277, § 38, 1988 Fla. Laws 1422, 1483 (codified at FLA. STAT. § 766.313 (Supp. 1988)).

417. FLA. STAT. § 95.11(4)(b) (1987).

418. Ch. 88-1, § 68(3), 1988 Fla. Laws 119, 178 (codified at FLA. STAT. § 766.309(3) (Supp. 1988)).

is denied a forum in which to litigate the claim against the hospital or assisting physicians. Likewise, the legislation does not specify whether a finding by a court is binding on the Association. Accordingly, the Association, in theory, may contest a claim before the deputy commissioner even where a judge or jury finds for the health care provider on its defense that the injury is qualified as a birth-related neurological injury. Such a result would deny the claimant the right to redress[419] and the right to due process.[420] Thus, the statute appears to be subject to an "unconstitutional as applied" challenge, and the courts may be required to fashion an appropriate remedy.[421]

The establishment of an exclusive no-fault plan for compensating infants who suffer certain injuries at birth clearly denies those infants their right to seek redress in the courts and a trial by jury where the injury is the result of medical negligence. But, it is intended to offer a balanced approach to solve a public crisis.[422] Like workers' compensation, it is designed to provide a reasonable alternative to recovery under the tort system and eliminates the need for the claimant to establish fault. Nonetheless, the plan is not necessarily free from constitutional challenges in its denial of both access to courts and a right to trial by jury. Since recovery is available only where the injury results from oxygen deprivation or mechanical failure occurring at birth,[423] the statute appears to require both proof of the injury and a causal connection between the birth process and the injury. While it does not require an actual showing of negligence, clearly it requires a greater degree of proof than is required under Florida's other no-fault system, workers' compensation.[424]

---

419. *See* FLA. CONST. art. I, § 21.

420. *See id.* § 9.

421. To some extent, this issue could be remedied by a rule requiring that the Florida Birth-Related Neurological Injury Compensation Association be named as a cross-defendant in any action in which the defendant raises the defense that the injury is covered under the Florida Birth-Related Neurological Injury Compensation Plan.

422. *See, e.g.*, Smith v. Department of Ins., 507 So. 2d 1080 (Fla. 1987). To sustain legislation in derogation of the right of access to the courts, the legislation must provide either commensurate benefits or a showing of overpowering necessity. Kluger v. White, 281 So. 2d 1 (Fla. 1973).

423. *See* ch. 88-277, § 36(2), 1988 Fla. Laws 1422, 1482 (codified at FLA. STAT. § 766.302(2) (Supp. 1988)).

424. Under workers' compensation, the claimant need only prove that the injury arose out of and in the course of employment. FLA. STAT. § 440.09(1) (1987). However, under the Florida Birth-Related Neurological Injury Compensation Plan, the plaintiff must prove not only that the injury arose from the birthing process, but that it was caused by either oxygen deprivation or a mechanical failure. *See supra* notes 370-80 and accompanying text.

VI. EMERGENCY ROOM AND TRAUMA CARE LIABILITY REFORM

The legislation concerning emergency room and trauma care liability focuses on lowering the standard of care,[425] limiting who may provide expert testimony in liability cases involving "emergency medical services,"[426] and requests the Supreme Court of Florida to establish standard jury instructions for such cases.[427] To guarantee the availability of emergency care, the 1988 Act limits the ability of hospitals to reduce emergency services[428] and prohibits physicians from agreeing among themselves to reduce emergency care delivery.[429]

In no area of medicine has the medical malpractice crisis been more evident than in emergency room and trauma care. From 1983 to 1987, emergency medicine physicians experienced greater liability premium increases than any other medical specialty.[430] Even physicians in medical specialties other than emergency medicine were susceptible to the liability crisis surrounding emergency care. One survey indicates that forty-three percent of medical malpractice cases against Florida neurosurgeons originated from emergency cases.[431] As a result, emergency rooms and trauma centers became the focus of a physician rebellion against medical malpractice. Some emergency rooms in South Florida closed while others curtailed services,[432] prompting the American Medical Association to declare South Florida "the Beirut" of medical malpractice.[433]

In response to the crisis, Governor Martinez organized the Governor's Task Force on Emergency Room and Trauma Care (Emergency Room Task Force) in early 1987.[434] The Emergency Room Task Force forwarded a number of specific reform proposals. One proposed to change the standard of care in medical malpractice cases involving

---

425. *See infra* notes 439-48 and accompanying text.

426. *See infra* notes 449-53 and accompanying text.

427. Ch. 88-277, § 45, 1988 Fla. Laws 1422, 1492.

428. *See infra* notes 455-56 and accompanying text.

429. *See infra* notes 457-59 and accompanying text.

430. TASK FORCE FACT-FINDING REPORT, *supra* note 2, at 29-30. Emergency room physicians experienced a 49% annual increase in premiums during the period. Other medical specialties with relatively large premium increases included obstetrics & gynecology (46%), thoracic surgery (44%), cardiovascular surgery (44%), neurological surgery (44%), and orthopedic surgery (42%). *Id.*

431. FLORIDA NEUROLOGICAL SOC'Y., FLORIDA NEUROLOGICAL LAWSUIT PROFILE (1987).

432. *See supra* note 81.

433. Ver Berkmoes, *South Florida Faces 'Semi-battlefield Condition' In Care*, AM. MED. NEWS, July 17, 1987, at 2.

434. REPORT OF THE GOVERNOR'S TASK FORCE ON EMERGENCY ROOM AND TRAUMA CARE (Mar. 31, 1987) [hereinafter EMERGENCY AND TRAUMA REPORT]. This group is distinct from the Academic Task Force for Review of the Insurance and Tort Systems (Task Force).

emergency care to gross negligence. Other recommendations included requiring physicians to provide emergency room coverage as a condition of hospital staff membership, establishing qualification criteria for expert witnesses in emergency care malpractice cases, and expanding funding for indigent emergency care.[435] Though the Governor initially failed to endorse the recommendations of the Emergency Room Task Force,[436] many of these concepts became a part of the 1988 medical malpractice legislation.

The other Task Force, whose recommendations helped to sculpt the 1988 Act, did not make any recommendations directed at emergency room or trauma care.[437] In considering the possibility of compensating medical injuries arising from emergency and trauma care on a no-fault basis, that Task Force noted the difficulty in defining emergency and trauma care. For example, it questioned whether the definition of an emergency or trauma case depends on where treatment is rendered, (i.e., in an emergency room as opposed to a physician's office), or if the critical distinction is whether the patient is treated by the person's own physician or by an "emergency medicine" specialist. An alternative, and perhaps more meaningful designation, defined the emergency or trauma patient according to the nature and severity of the patient's illness or injury. As a result of this definitional difficulty, the Task Force determined that no-fault compensation of medical injuries in emergency rooms and trauma centers would be "prohibitively expensive, at worst, and impossible to predict, at best."[438] Despite these difficulties, the perceived gravity of the emergency room liability crisis led the 1988 Legislature to address specific reforms to the problem.

The most celebrated liability reform in emergency and trauma medicine is the change in the standard of care required in cases arising from injuries received in emergency rooms and trauma centers. Prior law made no distinction between emergency and non-emergency situations with regard to the standard of care required of physicians practicing in offices or hospitals.[439] Generally, professionals, including

---

435. EMERGENCY AND TRAUMA REPORT, *supra* note 434, at 48.

436. *See id.*

437. TASK FORCE RECOMMENDATIONS, *supra* note 50, at 2-3.

438. *See id.* at 31-32.

439. Section 768.13(2)(b), Florida Statutes (1987), addressed physician liability arising from "code blue" emergencies in hospitals or trauma centers. "Code blue" emergencies generally are those involving cardiopulmonary arrest that require immediate application of cardiopulmonary resuscitation (CPR). The statute provided that any physician responding gratuitously and in good faith to such emergencies

> shall not be held liable for any civil damages as a result of such care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment where the person [physician] acts as a reasonably prudent person licensed to practice

physicians, are held to a standard of care commensurate with their special knowledge, training, and ability.[440] A physician's failure to meet this standard of care is actionable medical negligence.[441] The 1988 legislation alters the standard of care for physicians and hospitals rendering emergency care to patients in hospital emergency rooms and trauma centers.[442] Actionable malpractice in such cases occurs only when hospitals and physicians act in a manner which demonstrates "reckless disregard" for the life or health of the patient.[443] The reckless disregard standard applies only until the patient is stabilized and does not apply to care unrelated to the original emergency.[444] If the patient undergoes surgery as a result of the initial emergency, the reckless disregard standard applies until the patient stabilizes after surgery.[445]

While this alteration in the standard of care appears to be a gross deviation from the prior standard,[446] that is not the case. For purposes of the 1988 Act, the Legislature defined "reckless disregard" as conduct which, at the time services were rendered, the health care provider "knew or should have known" would be likely to result in

---

medicine who would have acted under the same or similar circumstances.

Id. While this statute superficially appears to impose a different standard of care in emergency situations, closer analysis reveals that the standard imposed— reasonable and prudent professional care under the circumstances—is identical to the standard imposed on physicians in non-emergency situations. This statute was amended in 1988. Ch. 88-277, § 42, 1988 Fla. Laws 1422, 1490 (codified at FLA. STAT. § 768.13(2)(b) (Supp. 1988)).

For physicians delivering care gratuitously and in good faith outside of traditional medical settings, a different standard is applied. The Good Samaritan Act provides that physicians in these instances are immune from civil liability as long as they act as "a reasonably prudent man would have acted under the same circumstances." FLA. STAT. § 768.13(2)(a) (1987). This appears to hold the physician to the same standard of care as a lay citizen. At any rate, section 768.13(2)(a), applies only to treatment rendered outside of traditional medical settings and has no relevance to emergency room or trauma center care.

440. *See, e.g.*, W. PROSSER & W. KEETON, *supra* note 112, § 32, at 186-87. In Florida, the professional standard of care is the "level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers." FLA. STAT. § 768.45(1) (1987). The standard of care for a Florida health care provider practicing as a "specialist" is determined by reference to other health care providers practicing in the same specialty. *Id.* § 768.45(2)(b). Health care providers not certified as specialists are held to a standard of care that is determined by reference to "similar health care providers" licensed in Florida. *Id.* § 768.45(2)(a).

441. FLA. STAT. § 768.45(1) (1987).

442. Ch. 88-277, § 42, 1988 Fla. Laws 1422, 1490 (codified at FLA. STAT. § 768.13(2)(b) (Supp. 1988)).

443. *Id.* (codified at FLA. STAT. § 768.13(2)(b)(1) (Supp. 1988)).

444. *Id.* (codified at FLA. STAT. § 768.13(2)(b)(2)(b) (Supp. 1988)).

445. *Id.* (codified at FLA. STAT. § 768.13(2)(b)(2)(a) (Supp. 1988)).

446. *See* W. PROSSER & W. KEETON, *supra* note 112, at § 34 (reckless is "[a]n act of an unreasonable character [intentionally] in disregard of a known or obvious risk").

injury to the patient.[447] In determining whether the health care provider should have known that the conduct would injure the patient, all circumstances surrounding the health care provider's relationship with the patient should be considered.[448]

Taking into account the legislative definition of "reckless disregard," it is not clear that the new standard of care is substantially different from the old. Conduct that a health care provider "knew or should have known" would be injurious to a patient qualifies as "negligent" under the prior standard. Conversely, it is difficult to imagine conduct actionably negligent under prior law which is not considered "reckless disregard" under present law. While the legal differences between the new and old standards may be minimal or absent, it is possible that the use of the words "reckless disregard" will have a practical effect. Juries may be hesitant to find "reckless disregard" when faced with health care providers who acted in good faith. Finally, the statute's emphasis on the circumstances surrounding the emergency, such as severity of illness or injury, absence of prior doctor-patient relationship, incomplete medical history, and lack of time for appropriate consultation, may add force to a defense attorney's trial presentation of these factors.

In addition to specifying the standard of care applicable in emergency rooms and trauma centers, the Legislature limited who may provide expert testimony in malpractice cases involving the delivery of emergency medical services in a hospital emergency room.[449] Expert testimony is allowed only from health care providers[450] with "substantial professional experience" in a hospital emergency setting within the preceding five years.[451] Prior law permitted expert testimony from health care providers similar to the defendant,[452] or in the court's discretion, from health care providers with sufficient teaching or practice experience in the preceding five years in a field related to the defendant's.[453] Theoretically, requiring the expert witness to have substan-

447. Ch. 88-277, § 42(2)(b)(3), 1988 Fla. Laws 1422, 1490 (codified at FLA. STAT. § 768.13(2)(b)(3) (Supp. 1988)).

448. *Id.* (codified at FLA. STAT. § 768.13(2)(b)(3)(a)-(e) (Supp. 1988)).

449. Ch. 88-1, § 78(6)(a), 1988 Fla. Laws 119, 184 (codified at FLA. STAT. § 766.102(6)(a) (Supp. 1988)).

450. The 1988 Act refers to physicians, osteopathic physicians, podiatrists, and chiropractors. *Id.*

451. *Id.* (codified at FLA. STAT. § 766.102(6)(b)(2) (Supp. 1988)). The 1988 Act defines substantial professional experience according to the custom and practice of emergency medicine in the same or similar localities as that involved in the claim. *Id.*

452. FLA. STAT. § 768.45(2)(c)(1) (1987).

453. *Id.* § 768.45(2)(c)(2).

tial experience will improve the qualifications of witnesses testifying at medical malpractice trials involving emergency care.

The 1988 Act also contains provisions designed to improve citizens' access to health care. Undoubtedly, these provisions are a response to the much publicized curtailments of emergency services in South Florida in 1986 and 1987.[454] The first of these provisions requires hospitals to obtain the approval of the Department of Health and Rehabilitative Services (HRS) before substantially reducing emergency room or trauma services.[455] To obtain HRS approval, the hospital must demonstrate that no public need exists for continuing the particular emergency room or trauma service.[456] The Legislature also took steps to prevent physicians from refusing to treat emergency room patients. Concerted action by physicians to curtail the availability of emergency services to patients is a basis for disciplinary action by the Department of Professional Regulation (DPR).[457] Additionally, DPR or the affected hospital may file suit in circuit court to enjoin physicians from violating the statute.[458] If an injunction is issued, a physician who violates the injunction is subject to a fine of at least $5,000.[459]

VII. CONCLUSION

The 1988 malpractice legislation offers not only hope for a final solution to the medical malpractice problems experienced in this state, but also an example for future legislatures which may address similarly complex and politically charged issues. The decision to assign these issues to academic study by an independent and neutral body permitted an open and thorough discussion of facts, perceptions, and options for reform. These panel members were able to voice opinions without concern for political reprisals from interest groups or from the electorate.

Whether the 1988 legislation will withstand inevitable constitutional challenges and improve the availability of medical liability insurance remains to be seen. What is clear, however, is that the Legislature, in following the studied advice of the Task Force, has been willing to take bold and innovative steps to solve a most difficult and controversial problem. Hopefully, the Legislature will follow the further advice

---

454. *See supra* note 81.

455. Ch. 88-1, § 4, 1988 Fla. Laws 119, 129 (codified at FLA. STAT. § 395.0146 (Supp. 1988)).

456. *Id.*

457. Ch. 88-277, § 9, 1988 Fla. Laws 1422, 1440 (codified at FLA. STAT. § 458.3295 (Supp. 1988)). The Legislature passed an identical provision for osteopathic physicians. *Id.* § 12, 1988 Fla. Laws at 1442 (codified at FLA. STAT. § 459.0145 (Supp. 1988)).

458. *Id.*

459. *Id.*

of the Task Force and permit the reforms to take hold for a sufficient period of time before it takes any further action.